

# HEALTH CARE REFORM

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Y 4. W 36: 103-87

Health Care Reform, Serial 103-87, ...

GS

BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON WAYS AND MEANS  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED THIRD CONGRESS  
FIRST SESSION

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## VOLUME VIII

### **President's Health Care Reform Proposals: Role of State Governments and Health Alliances**

NOVEMBER 5, 1993

### **Issues Relating to Risk Selection and Adjustment by Health Plans**

NOVEMBER 9, 1993

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## **Serial 103-87**

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Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PRINTING OFFICE

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WASHINGTON : 1994

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**PRESIDENT'S HEALTH CARE REFORM  
PROPOSALS: ROLE OF STATE GOVERN-  
MENTS AND HEALTH ALLIANCES**

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**FRIDAY, NOVEMBER 5, 1993**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, D.C.*

The subcommittee met, pursuant to call, at 10:20 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

FOR IMMEDIATE RELEASE  
THURSDAY, SEPTEMBER 30, 1993

PRESS RELEASE #18  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES HEARINGS  
ON  
HEALTH CARE REFORM:  
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a series of hearings on issues relating to the President's health care reform proposals.

The hearings will begin on Thursday, October 7, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building. They will continue on Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. Subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President's health care reform plan presents a comprehensive response to the nation's most pressing problem. The plan would commit the nation to universal health coverage and to cost containment -- goals we have been seeking for many years. The President's proposals are complex, and we want to explore this plan and the alternatives to it, thoroughly, before proceeding to mark up a bill. We, therefore, expect to hold hearings to examine various aspects of the proposals throughout the fall of 1993."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals.

**BACKGROUND:**

The first hearing, scheduled for October 7, will include testimony from representatives of affected groups, including labor unions, health care providers, and health insurers.

Testimony from Administration experts on various aspects of the President's proposals, including benefits, coverage, low-income subsidies, cost containment, governance, and Medicare proposals, will be heard by the Subcommittee at the next two hearings. The first day of Administration witnesses will be held on October 12, and the second day will be announced in a later press release.

At subsequent hearings the Subcommittee will receive testimony from Members of Congress and from representatives of other affected groups, including consumer and employer groups.

Testimony will be heard at additional hearings to focus on a series of priority health reform issues, including:

- (1) Role of State governments and the Federal Government, including the role and functions of the proposed National Health Board, the Department of Health and Human Services, and other Federal agencies;
- (2) Role and functions of the proposed health alliances;
- (3) Health cost containment, including premium caps and alternative mechanisms;
- (4) Proposed insurance reforms and their impact, risk selection, and risk adjustment;

(MORE)

- (5) Impact of the plan on underserved inner-city and rural areas;
- (6) Impact of the plan on low-income populations generally;
- (7) Medicare savings proposals;
- (8) Impact of the plan on the structure and future of the Medicare program, including the proposed Medicare drug benefit;
- (9) Alternatives to the plan, including single-payer options, and other managed-competition options;
- (10) Administrative simplification under the plan;
- (11) Quality assurance;
- (12) Fraud and abuse measures;
- (13) Retiree health benefits;
- (14) Long-term care benefit;
- (15) Proposed standard health benefit package;
- (16) Graduate medical education and academic medical centers;
- (17) Impact of the plan on other affected groups and individuals.

Hearings also will be scheduled by the full Committee on Ways and Means to consider financing issues (other than Medicare savings proposals) and other tax-related matters.

#### DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Members of Congress, individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland or Karen Ponzurick [(202) 225-1721] no later than the close of business on Friday, October 15, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline and after additional hearings have been scheduled.

Individuals and organizations must specify in their requests to testify on which topic they would like to be heard. Given the limited time for the Subcommittee to hear from public witnesses, it is likely that witnesses will be restricted to one scheduled appearance before the Subcommittee. Additional comments on other aspects of the President's proposals may be submitted for the printed record of the appropriate hearing.

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Witnesses are reminded that the Subcommittee has held extensive hearings on various health reform issues earlier this year. To the extent possible, witnesses need not restate previous testimony heard by the Subcommittee.

Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

(MORE)

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are requested to submit 300 copies of their prepared statements to the Subcommittee office, room 1114 Longworth House Office Building, at least 24 hours in advance of the scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

**WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:**

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

**FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

\* \* \* \* \*

FOR IMMEDIATE RELEASE  
WEDNESDAY, OCTOBER 6, 1993

PRESS RELEASE #19  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES ADDITIONAL HEARINGS  
ON  
HEALTH CARE REFORM:  
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will continue its series of hearings on issues relating to the President's health care reform proposals with two hearings focusing on testimony from Administration witnesses.

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m., will begin at 10:30 a.m. All other details for this hearing remain the same. (See Subcommittee press release #18, dated September 30, 1993.)

The Subcommittee will continue its hearings on Friday, October 15, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The dates, times, and rooms for subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President has put forward a comprehensive and complex plan to address the critical goals of universal coverage and cost containment. As a follow-up to full Committee hearings with the First Lady and Secretary Shalala, the Subcommittee will hold two hearings with additional Administration officials to explore the proposed health plan in detail."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

**BACKGROUND:**

On October 12, the Subcommittee will receive testimony from the Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck. Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

Judy Feder, Ph.D, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee on Friday, October 15th. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

\* \* \* \* \*

\* \* \* CHANGE IN SCHEDULE \* \* \*

FOR IMMEDIATE RELEASE  
FRIDAY, OCTOBER 8, 1993

PRESS RELEASE #19-REVISED  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
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THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES SCHEDULING CHANGES FOR HEARINGS  
ON  
HEALTH CARE REFORM:  
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today scheduling changes for the hearings on issues relating to the President's health care reform proposals with testimony from Administration witnesses. (See Subcommittee press release #19, dated October 6, 1993.)

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., will be held on Thursday, October 14, beginning at 10:00 a.m.

On Thursday, October 14, Judy Feder, Ph.D., Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

The Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck, originally scheduled to appear on Tuesday, October 12, 1993, instead will appear before the Subcommittee on Friday, October 15, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

For additional information about these hearings and other Subcommittee hearings, see Subcommittee press releases #18, dated September 30, 1993, and #19, dated October 6, 1993.

\* \* \* \* \*



FOR IMMEDIATE RELEASE  
FRIDAY, OCTOBER 15, 1993

PRESS RELEASE #20  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-7785

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ANNOUNCES ADDITIONAL HEARINGS  
ON  
HEALTH CARE REFORM:  
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The Subcommittee will hold a hearing on Thursday, October 21, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., with testimony from representatives of consumer groups.

On Friday, October 22, 1993, the Subcommittee will hear testimony from provider groups beginning at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about the hearings, see Subcommittee press release #18, dated September 30, 1993.

\* \* \* \* \*

FOR IMMEDIATE RELEASE  
WEDNESDAY, OCTOBER 20, 1993

PRESS RELEASE #21  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES ADDITIONAL HEARINGS  
ON  
HEALTH CARE REFORM:  
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The dates, times, rooms, and topics for the additional hearings are as follows:

Tuesday, October 26	9:00 a.m.	1100 Longworth	Provider groups
Thursday, October 28	10:00 a.m.	1100 Longworth	Labor representatives
Tuesday, November 2	10:00 a.m.	1100 Longworth	Long-term care issues
Thursday, November 4	11:00 a.m.	1100 Longworth	Impact on the economy and jobs
Friday, November 5	10:00 a.m.	1100 Longworth	Role of State governments and health alliances
Tuesday, November 9	10:00 a.m.	1310A Longworth	Issues relating to risk selection and adjustment by health plans
Monday, November 15	10:00 a.m.	1310A Longworth	Health care cost containment

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

\* \* \* \* \*

## \* \* \* CHANGE IN ROOM AND TOPIC \* \* \*

FOR IMMEDIATE RELEASE  
MONDAY, NOVEMBER 8, 1993

PRESS RELEASE #21-REVISED  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES A CHANGE IN ROOM AND TOPIC FOR THE HEARING ON  
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

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The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals scheduled for Monday, November 15, 1993, at 10:00 a.m. in room 1310A Longworth House Office Building, will be held instead in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. (See press release #21, dated Wednesday, October 20, 1993.)

The topic of this hearing will not be health care cost containment. Testimony will be heard instead from public witnesses on issues relating to benefits under the President's health care reform proposals.

The Subcommittee hearing on health care cost containment will be rescheduled at a later date.

\* \* \* \* \*

FOR IMMEDIATE RELEASE  
FRIDAY, JANUARY 14, 1994

PRESS RELEASE #23  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES ADDITIONAL HEARINGS  
ON  
HEALTH CARE REFORM:  
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional days of hearings to receive testimony from the public, as part of its series of hearings on issues relating to the President's health care reform proposals.

The first hearing will be held on February 1, 1994, in room 1310A Longworth House Office Building. This hearing will begin at 2:30 p.m. or, if necessary, upon completion of the earlier full Committee hearing.

The second hearing will be held on Friday, February 4, 1994, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will be individuals and organizations who have previously requested an opportunity to testify before the Subcommittee, in accordance with Subcommittee press release #18. All witnesses who will appear at these hearings will be notified in advance by the staff.

**WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:**

Persons submitting written statements for the printed record of the hearings should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

**FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

- 1 All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
- 2 Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
- 3 Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
- 4 A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

\* \* \* \* \*

\* \* \* NOTICE -- CHANGE IN TIME \* \* \*

FOR IMMEDIATE RELEASE  
MONDAY, JANUARY 24, 1994

PRESS RELEASE #23-REVISED  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
1102 LONGWORTH HOUSE OFFICE BLDG.  
WASHINGTON, D.C. 20515  
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,  
ANNOUNCES A TIME CHANGE FOR HEARING  
ON

HEALTH CARE REFORM:  
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

---

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals previously scheduled for Tuesday, February 1, 1994, at 2:30 p.m. in room 1310A Longworth House Office Building, will begin instead at 10:00 a.m.

All other details for the hearing remain the same. (See Subcommittee press release #23, dated January 14, 1994.)

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Chairman STARK. Good morning. The Chair apologizes for the tardiness of the Chair, and I recognize the promptness of the Ranking Member.

The Subcommittee on Health will continue its series of hearings on the administration's health reform plan and will focus today on the role of the States. We will also examine the responsibilities of and the necessity for the regional health alliances proposed under the Health Security Act, an institution which the Chair has characterized as an orphan looking for a set of parents.

It is no secret that I have reservations about the primacy of States under the proposed plan. For many reasons, I believe it is misguided to rely on 50 individual State governments, rather than the Federal Government, to enact and implement and enforce the health reform plan. That is not to suggest that States should not be offered an ample opportunity to have alternative plans if they choose and can meet the government standards. But there is ample evidence the States will not dedicate sufficient resources, nor in some cases are they able to operate a well-managed, well-regulated, State-based health system.

The reports of mismanagement by State-based Medicaid programs are well documented, one of the most severe being a decade or so ago in our own State of California. Moreover, under the watchful eye of State insurance regulators, consumers have been subjected to cherry picking, redlining, bankruptcies, unpaid claims and other practices by the health insurance industry, which have brought us partially to where we are today.

I am concerned that some States will not enact legislation required to implement the more controversial features of the national health reform plan. We have seen before that certain vested interests will be more effective blocking reform on the State level than they are here in Washington.

Take Oregon, with the rollback of their employer mandate. I do not think that residents of certain States should be denied universal coverage and access if the legislature and the Governor cannot agree to enact the reforms.

My third concern with the overall structure is a political one. The plan would require Federal legislators to be held accountable to their constituents for actions taken, or not taken, by 50 Governors and legislatures. How can I promise my constituents universal health coverage and cost controls, if the plan relies on Governor Wilson, who has announced his opposition to the plan, for its enactment and implementation? How can I ask my Republican colleague from Texas to rely on Governor Richards for the plan? This is not a political reality.

Finally, much has been made of health reforms currently under way at the State level. While there has been some increase in activity pertaining to health reform, only a handful of States have enacted what could optimistically be described as significant reform. And even those States do not yet have the guaranteed coverage and access that is the cornerstone of the President's plan.

The vast majority of States have done little with respect to health reform.

This country has had the opportunity to learn from a natural experiment which began in the early 1960s with Medicare and Medic-

aid, and the result is a State-based Medicaid program riddled with problems and inequities, and it has few, if any, defenders.

By contrast, the federally administered Medicare program, while not perfect, is successful, popular, efficient and well-run.

For these and other reasons, it would be misguided, in my view, to depend on each and every State to enact and implement the complex and controversial requirements of this plan. I would prefer to establish an underlying Federal program that encourages, rather than requires States to operate their own systems, provided that such systems meet defined Federal standards. Under such a system, those States which are able and willing to go forward with an approach that works best for the residents of their States could do so. And I would provide generous assistance for them to make that conversion. Others would not be required to take on more responsibility than they are able to deliver.

This hearing should also examine in some detail the anticipated role of the proposed regional health alliances. Since the concept of a health alliance is completely new and untested, many questions will need to be resolved before we even trust these alliances with the health of the American people.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I feel somewhat compelled to respond to your opening statement. Governor Wilson—and he is mentioned frequently here, and most people know that we both come from California—is a critic of the President's plan. I think it is worth examining the reasons why the Governor has stated that he is opposed to the President's plan. Interestingly enough, it is employer mandates, the unfunded mandates, and the financing mechanisms, some of which have been roundly criticized by both Republicans and Democrats from this dais in terms of the President's plan as well.

I think it is also important to note that Dr. Philip Lee, a prominent Californian who is now Assistant Secretary of Health at HHS, has said that California is ahead in reform, especially with the voluntary HIPC. Interestingly enough, HIPC, referring not to purchasing cooperatives, but the health insurance plan for California, originated this July in moving forward for small businesses, and is a key example of why California is ahead, along with the managed care waivers for Medicaid in 13 California counties, 2 of which are in my district.

Mr. Chairman, I don't share your frustration with the fact that the people and their representatives keep getting in the way of a process that you want to mandate from the Federal level. I happen to think the people and their representatives, whether in a State legislature or those people who are represented by people who are not on this committee, or even, heaven forbid, by Republicans, have equal rights in terms of determining what the plan looks like.

I think it needs to be noted—and I am sure they will speak for themselves—that the National Governors' Association does not endorse an employer mandate structure in terms of their outlines that they request.

I know that you have had some concern about, and at least have voiced some concerns about, the way in which the President's employer mandate is to operate. If, in fact, the people of Oregon have

decided to wait and see, I think they are only one of virtually all of the States who have been trying to move forward, given the failure of the Federal Government to provide a proper umbrella dealing with administrative simplification, insurance reforms, malpractice reforms, antitrust reforms, creating more flexibility for Medicaid, and making waivers easier. Thirty-eight States have a balanced budget mandate, and they are trying to meet the very real cost needs of the people in their States, without the Federal Government, working cooperatively together.

You have made mention numerous times of your desire to have a single-payer system with Medicare as the model, and I have sat here listening to you leading witnesses trying to get them to say that the Medicare system is very good, and I have heard over and over again that, gee, the way in which you reimburse the structure that is presented, it just really isn't very good.

It seems to me that the way that we are going to solve this problem is, all of the people of the United States, through the States and the Federal Government working cooperatively together, are going to solve this problem. I happen to think that the States in the last 2 to 3 years, and in this year and especially next year, as the Federal Government continues to fail to act, are going to continue to pass laws that create new, novel and innovative reforms. We need to look at what the States are doing. And we might even, heaven forbid, learn from what the States are doing.

So I am anxious and interested in listening to what the States have to offer.

Are all 50 States uniform in their ability to execute? No, and neither are all 50 States uniform in their needs. I think a single, one-size-fits-all Federal structure is just as wrong as your concern about some States not moving forward as rapidly as others. I believe there is plenty of ground for everyone working cooperatively together.

As far as a natural experiment in terms of Medicare and Medicaid, the only thing that I have noticed as a natural experiment is those who have been in power passing open-ended entitlements that have continued, to the best of your knowledge, to go beyond sight. That is a natural tendency of the Democratic Party. I don't know that the Medicare and Medicaid is a natural experiment.

What we are trying to do is end this open-ended entitlement; and in fact, the President has presented a new entitlement, the mother of all entitlements: universal coverage.

Let me say also that an employer mandate is not essential to either universal coverage or access for all, positions that you know I support and that Governor Wilson supports as well.

I look forward to the testimony of those people representing States, and especially those people who are going to continue to enlighten us on this new and novel animal called "alliances."

I thank the chairman.

Chairman STARK. Fine. Let the record show the gentleman from California is opposed to Medicare, and I—

Mr. THOMAS. The record shows I am opposed to any open-ended entitlement.

Chairman STARK. Let the record show that, too. He is opposed to Social Security and the Medicare.



And I recognize the gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

First, let me tell you what a pleasure it is to have NCSL here and Senator Resnick. I remember very vividly being in your position, testifying before this Committee on behalf of NCSL in past years, and wondering when the opening statements would ever end so that I would get a chance to get my words in.

But let me first say how pleased I am about the testimony today about the role that I hope States will play and have played in health care reform. The States have done remarkably well, considering the lack of direction from the national government on health care reform. States have moved forward in access issues, in coverage, insurance reform, have moved forward in cost containment in their own States and have done, I think, a real service to this Nation in providing ways in which we can provide access and quality and cost containment.

My Chairman, in his opening statement, was somewhat disappointed by the progress made by our States. But when you take a look at the obstacles that have been put in front of you by the national government—the problems of ERISA, the problems of interstate competition, the problems of financing—it is difficult to envision how the States really could have moved further than they have under our national health system.

If I have any disappointment, it has been of why it has taken so long for the national government to move forward on health care reform. We started talking about this in the 1930s. We were able to enact a major bill in the 1960s, and we have done virtually nothing since. That has been the disappointment, the Congress and the national government, and certainly not our States.

I think President Clinton has offered us a real opportunity. His approach allows the Federal Government to establish basically the rules of engagement, that we will have universal access and we will have cost containment, but that allows the States, with flexibility, to craft a system that is best for the people of your State. And hopefully, through competition and diversity and through the Federalism concept of the States being the areas to experiment, we will take the best that the States have offered, and we will develop the highest-quality health care for the people of this Nation. That is how I envision the Clinton proposal.

But I hope, as we go through this process, that the NCSL and the NGA and the other groups that are interested in the States' involvement, will watch us very closely, and will scrutinize the bill submitted by the President very closely to make sure that the flexibility you need is really there, so that if we hold you accountable to provide universal coverage and provide the financing mechanism—in this case through employer mandates, basically—and give you a challenge as to keeping the cost within certain ranges, that you have the flexibility to be able to accomplish those goals and maintain the high quality that our constituents are demanding.

So I encourage you to not consider today your last opportunity, but to watch us, watch what the administration is doing, and be prepared to offer us concrete suggestions for change that will give you the flexibility you need to respond to what we are all trying to achieve; and that is universal access to affordable quality care.

Thank you, Mr. Chairman.

Chairman STARK. We will begin the testimony today with the Honorable Cindy Resnick, a State Senator and the Minority Leader from the State of Arizona. She is representing the National Conference of State Legislatures. And accompanying Ms. Resnick is Joy Johnson Wilson, the Director of the Health Committee of the National Conference of State Legislatures.

We welcome both of you to the subcommittee, and as in the case of all of our witnesses today, your full written statements will be part of the record of this hearing; and we would ask you to summarize or expand on your testimony in any manner that you are comfortable with.

Please begin.

**STATEMENT OF HON. CINDY RESNICK, MINORITY LEADER,  
SENATE OF THE STATE OF ARIZONA, ON BEHALF OF THE  
NATIONAL CONFERENCE OF STATE LEGISLATURES**

Ms. RESNICK. Good morning, Mr. Chairman, distinguished Members of the subcommittee. Thank you very much for inviting NCSL to be here to participate in these hearings. We are honored.

My name is Cindy Resnick, Minority Leader of the Arizona State Senate. Today I am speaking on behalf of the National Conference of State Legislatures. I am pleased to be here today to discuss the States' role in President Clinton's health care reform proposal.

NCSL has endorsed no specific plan or approach; however, our goal is to help create a plan that provides for health care coverage for all residents of the United States, under Federal guidance, with a strong, meaningful role for the States in the program design and implementation, equity for and between States, and a strong fiscal base.

NCSL applauds the leadership that President Clinton has provided in calling for health care reform and his efforts to guarantee lifelong health care coverage. The six basic principles of the President's plan—security, simplicity, savings, quality, choice, and responsibility—are consistent with NCSL's policy.

I would now like to outline our areas of concern with the President's plan.

On the National Health Board, we are extremely pleased that States would be officially represented on the NHB. The administration has made some adjustments in the roles and responsibilities of the Board, given some of our concerns. We are pleased with those changes, but we still have concerns about the degree of power vested in the Board.

The NHB would establish and enforce budget targets. The States must have a role in developing the targets, and States, not the NHB, should enforce them and should be permitted to utilize the full range of strategies available to control costs while maintaining quality and guaranteeing access.

On the regional and corporate health alliances; the proposal gives States the primary regulatory authority over the regional health alliances. We believe that this is appropriate. The Federal Government should develop broad guidelines and let States determine the structure, function and governance of the health alliances.

On the corporate alliances, NCSL believes that participation in the regional health alliances should be as inclusive as possible. We see no strong public policy basis for the establishment of corporate alliances. In some States, if all the large employers were to choose to establish corporate alliances, the remaining individuals in that State may not represent a population large enough to provide the regional alliance with adequate negotiating strength in some of those areas. We are also concerned that firms will initially establish corporate alliances and then for financial reasons, work force reductions or expediency, decide to put their employees in regional alliances. The local impact of such changes have both budget and service delivery implications.

The bottom line here is that, while States will be held accountable, we will not be able to adequately plan. It would be simpler and more efficient to put everybody in the alliances and allow the States the flexibility to opt entities out, provided they could do so and meet the requirements of the law.

On the regional alliance boundaries, we urge the administration to permit more flexibility regarding the designation of alliance boundaries. I believe that the administration should reconsider the prohibition on establishing alliances that cross State lines. Smaller States, like Maine, may be able to establish more efficient service delivery systems and stronger risk pools if they are permitted to establish alliances with neighboring States.

Federal preemption is a concern to us. The Clinton proposal would preempt a broad range of State laws. We believe that all Federal preemption should be carefully scrutinized, and that there are certain areas where national uniformity is both necessary and desirable; and we should both work toward those goals together. For example, NCSL supports the establishment by the Federal Government of several standard benefit packages that would include insurance guidelines and operating standards, but believe States should continue to regulate insurance, including supplemental coverage.

We are concerned and pleased with the inclusion of essential community providers in the plan and the limitation that those providers are incremental participants in the new health care reform program. Primary responsibility for identifying these entities, however, should rest with the States.

In Arizona, for instance, the University of Arizona Student Health Center, 1 of only 75 accredited facilities in the country, has allied itself with managed care providers in the community to make itself more cost effective and to enhance the provider network. These kinds of alliances should be encouraged.

We know that we are concerned about the full integration of Medicaid into the health care package. We realize that it may be necessary to phase in this population. However, we are concerned that notch group individuals who are covered by State programs which cover broader categories of services than the current administration-proposed benefit package may be left out. A remedy to this issue needs to be considered immediately.

On the undocumented individuals, I know this is a big concern to both the Federal Government and the States. The Federal Government should address this problem and address it squarely. As

States, we have no ability or authority to control the flow of these individuals and must provide health care to them when they appear at our hospitals.

It is essential that the new system be adequately financed. The Clinton proposal provides that most employers would pay no more than 7.9 percent of payroll as a contribution to employee health coverage. Exempted from this cap on premiums are companies that opt to establish corporate alliances and State and local governments. According to the study done by AFCME, more than half of the States, however, already exceed the 7.9 percent cap. The majority of adversely affected States would be in the south.

On State taxes, the NCSL is very concerned that the President's plan may affect States in a number of negative ways. The plan would continue the restrictions placed on States regarding provider-related taxes and impose a 1.5 percent premium tax on health plans to provide support for graduate medical education. This shifts Federal financial responsibility away from the Federal Government and to the States.

The President has proposed to increase the Federal sales tax on cigarettes to 75 cents. Many States have increased cigarette taxes as well. Unfortunately, this proposal impacts the States who have already raised those moneys, and many of those States are using those additional revenues to expand coverage to women's and children's programs.

In the transition, we hope that the Congress will recognize that NCSL strongly supports an expedited waiver process so that the States may continue to propose innovative health care reform initiatives and bring them before the Federal bureaucracy for approval. We support the additional time afforded States to comply with the provisions of the health care reform legislation. States now have, thankfully, until 1997 to phase into the new system. It is critical that each State be able to begin with new program with a firm foundation in place.

In summary, our goal is to be active participants in developing a comprehensive reform strategy, and we look forward to working with you toward that goal.

[The prepared statement follows:]

TESTIMONY OF HON. CINDY RESNICK, ARIZONA STATE SENATOR  
NATIONAL CONFERENCE OF STATE LEGISLATURES

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

MY NAME IS CINDY RESNICK. I AM THE MINORITY LEADER OF THE ARIZONA STATE SENATE AND TODAY I AM SPEAKING ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES (NCSL).<sup>1</sup> I AM THE IMMEDIATE PAST CHAIR OF THE NCSL HEALTH COMMITTEE. MY TESTIMONY TODAY IS BASED ON NCSL POLICY WHICH REFLECTS OUR DEDICATION TO PRESERVING A STRONG FEDERAL SYSTEM OF GOVERNMENT, PROTECTING OUR NATION'S VULNERABLE POPULATIONS, DEVELOPING CREATIVE, CONSTRUCTIVE DOMESTIC INITIATIVES, AND FORGING AN EFFECTIVE STATE-FEDERAL HEALTHCARE REFORM PARTNERSHIP.

MY TESTIMONY TODAY IS BASED ON NCSL POLICY WHICH REFLECTS OUR DEDICATION TO PRESERVING A STRONG FEDERAL SYSTEM OF GOVERNMENT, PROTECTING OUR NATION'S VULNERABLE POPULATIONS, DEVELOPING CREATIVE, CONSTRUCTIVE DOMESTIC INITIATIVES, AND FORGING AN EFFECTIVE STATE-FEDERAL HEALTHCARE REFORM PARTNERSHIP.

I AM PLEASED TO BE HERE TODAY TO DISCUSS THE STATE ROLE IN PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL. NCSL HAS ENDORSED NO SPECIFIC PLAN OR APPROACH. OUR GOAL IS TO HELP CRAFT A PLAN THAT PROVIDES FOR: (1) HEALTH CARE COVERAGE FOR ALL RESIDENTS OF THE UNITED STATES; (2) FEDERAL GUIDANCE WITH A STRONG, MEANINGFUL ROLE FOR STATES IN PROGRAM DESIGN AND IMPLEMENTATION; (3) EQUITY FOR AND BETWEEN STATES; AND (4) A STRONG FISCAL BASE.

THE ONLY WAY TO PROVIDE FULL ACCESS AND TO CONTROL HEALTH CARE COSTS AND QUALITY OF CARE IS TO ESTABLISH A PROGRAM WHERE EVERYONE IS COVERED. WHILE WE AGREE THAT SOME NATIONAL UNIFORMITY IS DESIRABLE, WE WILL ACTIVELY OPPOSE FEDERAL PREEMPTION UNLESS PREEMPTION IS THE ONLY REASONABLE MEANS OF REACHING A COMPELLING NATIONAL OBJECTIVE. THE APPROPRIATE ROLE OF THE FEDERAL GOVERNMENT IS TO SET NATIONAL STANDARDS, AND TO ESTABLISH GOALS. EACH STATE SHOULD DETERMINE THE BEST WAY TO MEET THE GOALS AND TO IMPLEMENT THE NATIONAL STANDARDS. IT IS IMPORTANT TO PAY SPECIAL ATTENTION TO THE STATE-BY-STATE AND REGIONAL IMPACT OF HEALTH CARE REFORM PROPOSALS. MOREOVER, A FIRM FINANCIAL FOUNDATION IS CRITICAL TO THE ESTABLISHMENT AND FULL IMPLEMENTATION OF COMPREHENSIVE HEALTH CARE REFORM. ELIGIBILITY AND/OR COVERAGE MAY NEED TO BE PHASED-IN OVER TIME.

NCSL APPLAUDS THE LEADERSHIP THAT PRESIDENT CLINTON HAS PROVIDED IN CALLING FOR HEALTH CARE REFORM AND HIS EFFORTS TO GUARANTEE LIFELONG HEALTH CARE COVERAGE. THE SIX BASIC PRINCIPLES OF THE PRESIDENT'S PLAN; SECURITY, SIMPLICITY, SAVINGS, QUALITY, CHOICE, AND RESPONSIBILITY, ARE CONSISTENT WITH NCSL'S POLICY. I WOULD NOW LIKE TO OUTLINE OUR AREAS OF CONCERN WITH THE PRESIDENT'S PLAN.

#### NATIONAL HEALTH BOARD

WE ARE EXTREMELY PLEASED THAT STATES WOULD BE OFFICIALLY REPRESENTED ON THE NATIONAL HEALTH BOARD (NHB). NCSL IS NOT HOWEVER, COMFORTABLE WITH THE PROPOSED ROLES AND RESPONSIBILITIES OF THE BOARD. THE ADMINISTRATION HAS MADE SOME ADJUSTMENTS IN THE ROLES AND RESPONSIBILITIES OF THE BOARD THAT GIVES MORE AUTHORITY TO STATE GOVERNMENTS. WE BELIEVE THIS IS MOVEMENT IN THE RIGHT DIRECTION, BUT STILL HAVE CONCERNS ABOUT THE DEGREE OF POWER VESTED IN THE BOARD.

THE NHB WOULD ESTABLISH AND ENFORCE BUDGET TARGETS. NCSL HAS TAKEN NO POSITION ON WHETHER BUDGET TARGETS SHOULD BE ESTABLISHED, BUT BELIEVES THAT, IF TARGETS ARE ESTABLISHED, STATES MUST HAVE A ROLE IN DEVELOPING THEM AND STATES, NOT THE NHB, SHOULD ENFORCE THEM AND SHOULD BE PERMITTED TO UTILIZE THE FULL RANGE OF STRATEGIES AVAILABLE TO CONTROL COST WHILE MAINTAINING QUALITY AND GUARANTEEING ACCESS.

#### REGIONAL AND CORPORATE HEALTH ALLIANCES

THE PROPOSAL GIVES STATES THE PRIMARY REGULATORY AUTHORITY OVER THE REGIONAL HEALTH ALLIANCES. WE BELIEVE THIS IS APPROPRIATE. THE FEDERAL GOVERNMENT SHOULD DEVELOP BROAD GUIDELINES AND LET STATES DETERMINE THE STRUCTURE, FUNCTION AND GOVERNANCE OF THE HEALTH ALLIANCES.

NCSL BELIEVES THAT PARTICIPATION IN THE REGIONAL HEALTH ALLIANCES SHOULD BE AS INCLUSIVE AS POSSIBLE. WE SEE NO STRONG PUBLIC POLICY BASIS FOR THE ESTABLISHMENT OF CORPORATE ALLIANCES. THE LAW WOULD REQUIRE STATES TO: "... ENSURE THAT EACH ALLIANCE ENCOMPASSES A POPULATION LARGE ENOUGH TO ENSURE THAT THE ALLIANCE HAS

1 NCSL REPRESENTS THE LEGISLATURES OF THE FIFTY STATES, ITS COMMONWEALTHS, TERRITORIES AND THE DISTRICT OF COLUMBIA.

ADEQUATE MARKET SHARE TO NEGOTIATE EFFECTIVELY WITH HEALTH PLANS PROVIDING THE COMPREHENSIVE BENEFIT PACKAGE TO ELIGIBLE INDIVIDUALS WHO RESIDE IN THE AREA." IN SOME SMALL STATES, IF ALL THE LARGE EMPLOYERS WERE TO CHOOSE TO ESTABLISH CORPORATE ALLIANCES, THE REMAINING INDIVIDUALS MAY NOT REPRESENT A POPULATION LARGE ENOUGH TO PROVIDE THE REGIONAL ALLIANCE WITH ADEQUATE NEGOTIATING STRENGTH, IN SOME GEOGRAPHICAL AREAS.

WE ARE ALSO CONCERNED THAT FIRMS WILL INITIALLY ESTABLISH CORPORATE ALLIANCES AND THEN FOR FINANCIAL REASONS OR EXPEDIENCY, DECIDE TO PUT THEIR EMPLOYEES IN REGIONAL ALLIANCES. WE WOULD ALSO HAVE TO BE CONCERNED ABOUT ECONOMIC DOWNTURNS DURING WHICH THESE EMPLOYERS MAY LAYOFF WORKERS OR IN THE CASE I AM MOST FAMILIAR WITH, SEASONAL LABOR FORCE REDUCTIONS. THE LOCAL IMPACT OF SUCH CHANGES HAVE BOTH BUDGET AND SERVICE DELIVERY IMPLICATIONS. THE BOTTOM LINE HERE IS THAT WHILE STATES WILL BE HELD ACCOUNTABLE, WE WILL NOT BE ABLE TO ADEQUATELY PLAN. IT WOULD BE SIMPLER AND MORE EFFICIENT TO PUT EVERYBODY IN THE ALLIANCES AND TO ALLOW STATES TO OPT ENTITIES OUT PROVIDED THEY COULD DO SO AND MEET THE REQUIREMENTS OF THE LAW.

WE URGE THE ADMINISTRATION TO PERMIT MORE FLEXIBILITY REGARDING THE DESIGNATION OF ALLIANCE BOUNDARY LINES. I BELIEVE THAT THE ADMINISTRATION SHOULD RECONSIDER THE PROHIBITION ON ESTABLISHING ALLIANCES THAT CROSS STATE LINES. STATES MAY BE ABLE TO ESTABLISH MORE EFFICIENT SERVICE DELIVERY SYSTEMS AND STRONGER RISK POOLS IF THEY WERE PERMITTED TO ESTABLISH ALLIANCES WITH NEIGHBORING STATES. WE ARE ALSO NOT AT ALL CERTAIN THAT THE REQUIREMENT THAT ALLIANCES BE ESTABLISHED BY STANDARD METROPOLITAN STATISTICAL AREAS (SMSA) IS EITHER DESIRABLE OR WORKABLE.

#### FEDERAL PREEMPTION

THE CLINTON PROPOSAL WOULD PREEMPT A BROAD RANGE OF STATE LAWS. WE BELIEVE THAT ALL FEDERAL PREEMPTION SHOULD BE CAREFULLY SCRUTINIZED. THERE ARE CERTAINLY AREAS WHERE NATIONAL UNIFORMITY IS BOTH NECESSARY AND DESIRABLE, BUT NCSL IS NOT WILLING TO CEDE STATE AUTHORITY IN AREAS WHERE THERE IS NO CLEAR NEED TO DO SO.

FOR EXAMPLE, NCSL SUPPORTS THE ESTABLISHMENT, BY THE FEDERAL GOVERNMENT, OF SEVERAL STANDARD BENEFIT PACKAGES THAT WOULD INCLUDE INSURANCE GUIDELINES AND OPERATING STANDARDS, BUT BELIEVES STATES SHOULD CONTINUE TO REGULATE INSURANCE, INCLUDING SUPPLEMENTAL COVERAGE. THE PRESIDENT'S PROPOSAL WOULD ESTABLISH A FEDERAL CONSUMER PROTECTION FRAMEWORK BY MANDATING THE ESTABLISHMENT OF A STATE HEALTH ALLIANCE GRIEVANCE PROCEDURE. STATE INSURANCE COMMISSIONERS CURRENTLY CARRY OUT THESE DUTIES, AND WE SEE NO REASON TO DUPLICATE EXISTING STATE EFFORTS THROUGH THE ESTABLISHMENT OF A FEDERAL GRIEVANCE FRAMEWORK OR PROGRAM.

STATES, OVER THE PAST SEVERAL YEARS HAVE ENACTED A BODY OF LAW THAT HAS AT TIMES BEEN CHARACTERIZED AS "ANTI- MANAGED CARE", BUT THEY SHOULD MORE CORRECTLY BE CHARACTERIZED AS LAWS REGULATING MANAGED CARE. THESE LAWS TYPICALLY: (1) REQUIRE LICENSURE OR CERTIFICATION BY THE STATE; (2) ESTABLISH QUALIFICATION AND TRAINING REQUIREMENTS FOR UTILIZATION REVIEW PERSONNEL; (3) REQUIRE AGENTS TO PROVIDE INFORMATION ON HOW DECISIONS ARE MADE; (4) REQUIRE INSURERS TO INVESTIGATE COMPLAINTS; (5) REQUIRE THAT LOCAL STANDARDS OF HEALTH CARE PRACTICE BE USED FOR UTILIZATION REVIEW; AND (6) ASSIGN THE REGULATORY AUTHORITY FOR UTILIZATION REVIEW AGENTS TO AN APPROPRIATE STATE AGENCY. THESE LAWS SET STANDARDS FOR HOW MANAGED CARE PROVIDERS OPERATE WITHIN THE STATE AND REGULATE UTILIZATION REVIEW COMPANIES, BOTH IMPORTANT FUNCTIONS FOR CONSUMER PROTECTION. THE CLINTON PLAN PREEMPTS THESE LAWS, BUT IS SILENT REGARDING WHAT THE FEDERAL GOVERNMENT WILL DO TO PROTECT CONSUMERS AND ENSURE QUALITY.

THE PROPOSAL WOULD ALSO PREEMPT STATE LAWS WHICH ESTABLISH THE SCOPE OF PRACTICE OF HEALTH PROFESSIONALS LICENSED OR CERTIFIED TO PRACTICE IN THE STATE. WE STRONGLY SUPPORT THE FEDERAL GOAL OF EXPANDING ACCESS THROUGH THE USE OF PHYSICIAN ASSISTANTS, NURSES, AND ALLIED HEALTH PROFESSIONALS, BUT WE BELIEVE PROFESSIONAL REGULATION SHOULD BE THE PURVIEW OF THE LEVEL OF GOVERNMENT THAT LICENSES AND CERTIFIES THE HEALTH CARE PROVIDERS.

#### ESSENTIAL COMMUNITY PROVIDERS

THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS BEEN GIVEN THE AUTHORITY TO DESIGNATE CERTAIN PROVIDERS AS "ESSENTIAL COMMUNITY PROVIDERS". CERTIFIED HEALTH PLANS WOULD BE REQUIRED TO INCLUDE THESE PROVIDERS IN THEIR NETWORKS INITIALLY FOR A FIVE-YEAR PERIOD. THIS REQUIREMENT IS DESIGNED TO ENSURE THAT PROVIDERS WHO HAVE TRADITIONALLY CARED FOR LOW INCOME PERSONS, OFTEN IN

UNDERSERVED AREAS, WILL BE AFFORDED AN OPPORTUNITY TO PARTICIPATE IN THE NEW SYSTEM. NCSL SUPPORTS THIS CONCEPT.

NCSL POLICY CALLS FOR THE INCLUSION OF COMMUNITY HEALTH CENTERS, SCHOOL CLINICS, PUBLIC HEALTH CLINICS AND OTHER COMMUNITY PROVIDERS IN THE NETWORK OF PROVIDERS ELIGIBLE TO PROVIDE SERVICES AS LONG AS THEY MEET THE ESTABLISHED STANDARDS AND STATE REGULATIONS. THE PRIMARY RESPONSIBILITY FOR IDENTIFYING AND THE DESIGNATION OF THESE PROVIDERS SHOULD BE A STATE FUNCTION IN COLLABORATION WITH LOCAL GOVERNMENTS. THE PRESIDENT'S PROPOSAL ASSIGNS NO ROLE IN THIS PROCESS FOR STATE GOVERNMENTS, YET STATES ARE RESPONSIBLE FOR ENSURING THAT THE HEALTH CARE DELIVERY SYSTEMS WITHIN THEIR BORDERS ARE ABLE TO PROVIDE SERVICES TO ALL RESIDENTS.

#### WORKERS COMPENSATION AND AUTOMOBILE INSURANCE

THE PRESIDENT WANTS TO FULLY INTEGRATE THE HEALTH COMPONENT OF WORKERS COMPENSATION AND AUTOMOBILE INSURANCE INTO THE COMPREHENSIVE REFORM PACKAGE. NCSL HAS NO FORMAL POSITION ON WHETHER OR NOT THEY SHOULD BE INCLUDED; WE BELIEVE THAT STATES MUST BE ASSURED THAT THE CORE VALUES, SUCH AS BROAD COVERAGE, SAFE AND HEALTHFUL WORKPLACES, PROMPT AND HIGH QUALITY HEALTH CARE, ARE PRESERVED AND THAT NEITHER THE LIABILITY NOR THE EXCLUSIVE REMEDY DOCTRINE BE ALTERED. THIS AREA OF CHANGE NEEDS CAREFUL CONSIDERATION AND INPUT FROM STATE GOVERNMENTS.

#### MEDICAID

WE SUPPORT FULL INTEGRATION OF THE ACUTE CARE PORTION OF MEDICAID. AS STATE LEGISLATORS, WE HAVE EXTENSIVE EXPERIENCE WITH THE MEDICAID PROGRAM. THE PROGRAM HAS PROPPED UP OUR WEAK HEALTH CARE SYSTEM FOR A NUMBER OF YEARS, BUT DOES NOT PROVIDE A FIRM FOUNDATION FOR A NEW SYSTEM. TRUE EQUITY IN OUR HEALTH CARE SYSTEM REQUIRES THAT WE DECOUPLE HEALTH CARE SERVICES FROM ELIGIBILITY FOR CASH ASSISTANCE PROGRAMS.

WE KNOW THAT IF THE MEDICAID PROGRAM IS FULLY INTEGRATED, SOME INDIVIDUALS WOULD RECEIVE LESS COVERAGE THAN THEY ARE ELIGIBLE TO RECEIVE TODAY UNDER MEDICAID. FOR EXAMPLE, IF THE MEDICAID PROGRAM IN THE STATE WHERE AN INDIVIDUAL RESIDES COVERS SERVICES NOT INCLUDED IN THE ADMINISTRATION'S STANDARD BENEFIT PACKAGE, THEY IN EFFECT LOSE BENEFITS. UNDER THE ADMINISTRATION PROPOSAL, WHICH ONLY PARTIALLY INTEGRATES THE ACUTE CARE PORTION OF MEDICAID INTO THE SYSTEM, NONCASH MEDICAID RECIPIENTS WOULD LOSE THIS "RESIDUAL" MEDICAID COVERAGE. INDIVIDUALS WHO ARE CATEGORICALLY ELIGIBLE FOR MEDICAID BY VIRTUE OF THEIR ELIGIBILITY FOR AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) OR SUPPLEMENTAL SECURITY INCOME (SSI) WOULD CONTINUE TO BE ELIGIBLE FOR AND STATES WOULD BE REQUIRED TO PROVIDE RESIDUAL MEDICAID COVERAGE.

BUILDING ON THIS APPROACH, THE ADMINISTRATION HAS PROPOSED A NEW PROGRAM TO PROVIDE ADDITIONAL "RESIDUAL MEDICAID COVERAGE" TO CERTAIN CHILDREN IN LOW-INCOME HOUSEHOLDS. THIS NEW PROGRAM FOR CHILDREN, AND THIS APPROACH IN GENERAL VIOLATES ONE OF THE ADMINISTRATION'S SIX PRINCIPLES FOR HEALTH CARE REFORM: SIMPLICITY. THE NEW CHILDREN'S PROGRAM HAS THREE SEPARATE ELIGIBILITY CATEGORIES FOR CHILDREN UP TO AGE EIGHTEEN. MOREOVER, THE PROGRAM IS FUNDED AS A CAPPED ENTITLEMENT.

IF THE ADMINISTRATION BELIEVES THAT THE COMPREHENSIVE, STANDARD BENEFIT PACKAGE FAILS TO PROVIDE ADEQUATE COVERAGE FOR CERTAIN INDIVIDUALS, ADULT OR CHILDREN, THE ELIGIBILITY SHOULD BE STANDARD AND THE FINANCING SHOULD BE CLEARLY SET OUT. IF THE INDIVIDUALS ARE TO BE ENTITLED TO THESE BENEFITS, THE PROGRAM SHOULD NOT BE CAPPED.

THE ADMINISTRATION MAKES A FEW IMPROVEMENTS TO THE LONG TERM CARE COMPONENT OF MEDICAID. WE ARE GENERALLY SUPPORTIVE. NCSL IS STUDYING THE PROVISIONS OF THE LAW THAT WOULD PERMIT STATES TO INTEGRATE ALL STATE LONG TERM CARE PROGRAMS INTO ONE. WE ARE CONCERNED THAT INDIVIDUALS WOULD NO LONGER BE ENTITLED TO LONG TERM CARE SERVICES; HOWEVER, SINCE THE PROGRAM IS CAPPED, THAT WOULD PROBABLY BE A NECESSARY CONDITION.

#### COVERAGE FOR UNDOCUMENTED INDIVIDUALS

WE UNDERSTAND THE PUBLIC POLICY CONCERNS REGARDING COVERAGE OF UNDOCUMENTED INDIVIDUALS; HOWEVER, WE FEEL STRONGLY THAT THE FEDERAL GOVERNMENT SHOULD ADDRESS THIS PROBLEM SQUARELY. AS STATES, WE HAVE NO ABILITY OR AUTHORITY TO CONTROL THE FLOW OF UNDOCUMENTED INDIVIDUALS AND MUST PROVIDE HEALTH CARE TO

THESE PERSONS WHEN THEY APPEAR AT THE HOSPITAL OR CLINIC DOOR. WE SHOULD NOT BE LEFT UNASSISTED OR INADEQUATELY ASSISTED, TO PROVIDE HEALTH CARE TO THEM. SOME FUNDING WILL BE SET ASIDE TO REIMBURSE HOSPITALS FOR CARE THEY PROVIDE TO UNDOCUMENTED INDIVIDUALS, AND EMERGENCY CARE THROUGH THE MEDICAID PROGRAM WILL CONTINUE TO BE AVAILABLE. A MORE ADEQUATE AND SPECIFIC RESPONSE TO THIS PROBLEM IS ESSENTIAL. CERTAIN STATES WILL BE VERY ADVERSELY AFFECTED DUE TO THE LARGE NUMBERS OF UNDOCUMENTED INDIVIDUALS WITHIN THEIR BORDERS.

#### FINANCING

IT IS ESSENTIAL THAT THE NEW SYSTEM BE ADEQUATELY FINANCED. WHILE NCSL HAS TAKEN NO POSITION ON THE ADVISABILITY OF AN EMPLOYER MANDATE, WE BELIEVE THAT, IF SUCH A REQUIREMENT IS INCLUDED IN THE PLAN, SUBSIDIES FOR SMALL, AT-RISK BUSINESSES MUST BE PROVIDED. NCSL SUPPORTS MANDATORY PARTICIPATION BY INDIVIDUALS AND BELIEVES THAT SUBSIDIES MUST ALSO BE AVAILABLE FOR LOW-INCOME INDIVIDUALS AND THEIR FAMILIES. THE CLINTON PROPOSAL PROVIDES FOR SUBSIDIES, BUT HAS ESTABLISHED THESE SUBSIDIES AS A "CAPPED ENTITLEMENT", SUBJECT TO THE APPROPRIATIONS PROCESS. WE OPPOSE THIS PROPOSAL. A MANDATE FOR BUSINESSES AND INDIVIDUALS REGARDING PARTICIPATION AND COVERAGE REQUIRES GUARANTEED SUBSIDIES. WITHOUT ADEQUATE SUBSIDIES, UNIVERSAL COVERAGE WILL NEVER BE A REALITY. WE SUPPORT THE PROPOSAL TO PERMIT SELF-EMPLOYED INDIVIDUALS TO ENJOY THE SAME TAX DEDUCTIBILITY BENEFITS AFFORDED TO OTHER BUSINESSES.

THE CLINTON PROPOSAL PROVIDES THAT MOST EMPLOYERS WOULD PAY NO MORE THAN 7.9 PERCENT OF PAYROLL AS A CONTRIBUTION TO THEIR EMPLOYEE'S HEALTH CARE COVERAGE. EXEMPTED FROM THIS "CAP ON PREMIUMS", ARE COMPANIES THAT OPT TO ESTABLISH CORPORATE ALLIANCES, AND STATE AND LOCAL GOVERNMENTS. ACCORDING TO A STUDY CONDUCTED BY THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES (AFSCME), MORE THAN HALF OF THE STATES WOULD EXCEED THE 7.9 PERCENT CAP USING THE ADMINISTRATION'S ESTIMATE THAT THE AVERAGE PREMIUMS WILL BE \$4,200 FOR A FAMILY AND \$1,800 FOR AN INDIVIDUAL IN 1993. THE MAJORITY OF THE ADVERSELY AFFECTED STATES WOULD BE IN THE SOUTH. TOTAL PUBLIC SECTOR PREMIUMS IN EXCESS OF THE 7.9 PERCENT OF PAYROLL IS ESTIMATED TO BE \$1.2 BILLION IN 1997, A VERY HIGH PRICE TAG FOR STATES TO BEAR. THE ADMINISTRATION PROPOSES TO BEGIN PHASING-IN THE CAP FOR STATE AND LOCAL GOVERNMENTS IN 2002. THAT IS CLEARLY NOT SOON ENOUGH.

WE ARE CONCERNED ABOUT WHAT WE BELIEVE ARE UNREALISTIC SAVINGS THE ADMINISTRATION HOPES TO ACHIEVE FROM THE MEDICAID AND MEDICARE PROGRAMS. IF THESE SAVINGS CANNOT BE REALIZED, THE OVERALL PROGRAM IS NOT ADEQUATELY FINANCED.

FINALLY, THE PRESIDENT'S PLAN AFFECTS STATE TAXES IN A NUMBER OF WAYS. THE PLAN WOULD CONTINUE THE RESTRICTIONS PLACED ON STATES REGARDING PROVIDER-RELATED TAXES; AND IMPOSES A 1.5 PERCENT PREMIUM TAX ON HEALTH PLANS TO PROVIDE SUPPORT FOR GRADUATE MEDICAL EDUCATION. WE OPPOSE THESE PROVISIONS. THE PREMIUM TAX IS A TRADITIONAL STATE REVENUE SOURCE THAT WE BELIEVE SHOULD NOT BE COMPROMISED.

IN ADDITION, THE PRESIDENT HAS PROPOSED TO INCREASE THE FEDERAL SALES TAX ON CIGARETTES TO 75 CENTS. SIN TAXES ARE ANOTHER TRADITIONAL STATE REVENUE SOURCE. CURRENTLY MANY STATES FUND HEALTH PROGRAMS WITH A PORTION OF THEIR SALES TAX ON CIGARETTES. WE WOULD ASK THAT THE FEDERAL GOVERNMENT INCLUDE THE CIGARETTE TAX REVENUE, WE AS STATES WILL LOSE DUE TO LOWER CONSUMPTION AND HENCE REDUCED SALES AT LEAST FOR A WHILE, AS PART OF OUR FINANCIAL CONTRIBUTION TO THE OVERALL HEALTH CARE REFORM EFFORT.

#### TRANSITION

VICE PRESIDENT GORE, IN HIS RECENTLY RELEASED NATIONAL PERFORMANCE REVIEW, STRONGLY URGES THE DEVELOPMENT OF AN EXPEDITED AND EXPANDED WAIVER PROCESS. NCSL STRONGLY SUPPORTS THIS PROPOSAL. WE FURTHER BELIEVE THAT, WHILE THE FEDERAL GOVERNMENT DEBATES THE DETAILS OF HEALTH CARE REFORM, STATES SHOULD BE AFFORDED MAXIMUM FLEXIBILITY TO BEGIN INNOVATIVE REFORM OF THEIR HEALTH CARE DELIVERY SYSTEMS. NCSL SUPPORTS THE ESTABLISHMENT AND IMPLEMENTATION OF AN EXPEDITED WAIVER PROCESS BY WHICH STATES CAN RECEIVE MULTI-YEAR WAIVERS OF REQUIREMENTS UNDER MEDICAID, MEDICARE, ERISA AND OTHER FEDERAL LAWS IN ORDER TO IMPLEMENT STATE REFORMS. ERISA, IN PARTICULAR, IN ITS PRESENT FORM, PRESENTS A STUMBLING BLOCK TO STATE EFFORTS TO DESIGN UNIVERSAL HEALTH CARE COVERAGE SYSTEMS.

WE ALSO SUPPORT THE ADDITIONAL TIME AFFORDED STATES TO COMPLY WITH THE PROVISIONS OF THE HEALTH CARE REFORM LEGISLATION. STATES WILL NOW HAVE UNTIL THE



END OF 1997 TO PHASE-IN TO THE NEW SYSTEM. WHILE SOME STATES MAY BE ABLE TO MAKE THE NECESSARY LEGISLATIVE, BUDGETARY, AND HEALTH CARE INFRASTRUCTURE CHANGES NECESSARY TO FULLY IMPLEMENT THE REFORM PROGRAM BY 1996, SOME STATES WILL NEED THE ADDITIONAL TIME. IT IS CRITICAL THAT EACH STATE BE ABLE TO BEGIN THE NEW PROGRAM WITH A FIRM FOUNDATION IN PLACE.

#### CONCLUSION

IN SUMMARY, OUR GOAL IS TO BE ACTIVE PARTICIPANTS IN DEVELOPING A COMPREHENSIVE REFORM STRATEGY BASED ON FOUR PRINCIPLES: (1) UNIVERSAL COVERAGE; (2) A STRONG ROLE FOR STATES IN PROGRAM DESIGN AND IMPLEMENTATION UNDER GENERAL FEDERAL GUIDANCE; (3) EQUITY FOR AND BETWEEN STATES; AND (4) A FIRM FISCAL FOUNDATION. WE WILL APPLY THESE PRINCIPLES TO OUR ANALYSIS OF EACH HEALTH CARE REFORM PROPOSAL.

I APPRECIATE THIS OPPORTUNITY TO SHARE OUR INITIAL VIEWS REGARDING PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL WITH YOU AND I LOOK FORWARD TO WORKING WITH ALL OF YOU OVER THE COMING MONTHS.

THANK YOU AND I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Chairman STARK. Thank you. Perhaps we could talk a little bit just about your experience, if you wouldn't mind, and your own estimate of just what might or might not happen in Arizona.

Ms. RESNICK. Sure.

Chairman STARK. Because as I say, each State will have a different experience as they go through this. In spite of my colleague's concern, I have absolutely no quarrel with States going ahead and doing their own plan, if, in fact, they have universal access of coverage and can contain the costs. I am sure that Mr. Cardin agrees with me on that.

My worry is that that may be in some States difficult, just for the legislatures and the Governors to get together. Our own State might have that problem, depending on who is Governor and when we do it. And I think it is a fact.

I think that trial lawyers, for example, and insurance agents have much more clout in statehouses than they do back here, because we don't regulate them. So we don't see them as often as you very well may in Arizona.

But you, I think, have touched on the—on some of the concerns. But as I read the bill, the States would be responsible for subsidies if the cap entitlement doesn't cover the costs. Now, if you agree with the way I read it, then what would happen in Arizona?

Ms. RESNICK. Mr. Stark, we do agree, in fact, with your position that if subsidies are insufficient, the States will be left holding the bag. In Arizona, in particular, it might have a very negative impact, given that our State Medicaid program, for instance, is a very generous—as you would expect—Medicaid program.

Although it is managed care, we do not separate out services. We try to provide a very comprehensive package of benefits. What then would we do if the benefit package is less than what we are currently providing or subsidies are insufficient to provide for those additional services to those populations?

Obviously, the program would have to be cut, but how? In what area would you cut first? Benefits or dollars to the program, or to the doctors and the providers? We happen to believe that providers in our community are absolutely imperative, essential individuals who must be in the program. If we don't have a decent provider network, we cannot provide services to the people in our Medicaid population. That would be true in any State, given universal access.

Chairman STARK. And you and I are aware of many States, including California—maybe not as currently, but certainly in the recent past—where access to Medicaid isn't available for the very reason you just said. We were not paying the providers sufficiently, and they just didn't provide.

Ms. RESNICK. Right.

Chairman STARK. And, therefore, while we may have had Medicaid coverage in a lot of States, we just didn't have access.

When I suggest that the States have a dismal record in managing Medicaid, I would stipulate that the principal reason is that they haven't had the money. While I still would say that I insist that, on balance, Medicaid has been a failure for the pretty simple reason that we have served it to death; and I don't know as the States can do any better on a program that is not apt to have the

money coming in, particularly if we mandate the benefits at the Federal level.

By the same token, it is suggested by the White House that, of course, if your alliance runs out of money, we are supposed to pass the bill to fix that. So it cuts both ways. I mean, if you guys do a lousy job, then I am on the hook to vote the money for Arizona, to bail out Arizona. Isn't that how you read it?

Ms. RESNICK. I think it is the same situation you had a couple of years ago with provider taxes.

Chairman STARK. We have separated the responsibilities and the authorities in this.

Ms. RESNICK. Yes, sir.

Chairman STARK. In other words, we give somebody the responsibility, not the money.

Ms. RESNICK. Right.

Chairman STARK. And that is a problem that I have in the structure that we have here.

Now, unlike most employers, you all are not subject to this 7.9 percent cap on contributions. What will that do to your State and local employees' plans? Have you thought that one through?

Ms. RESNICK. I am sorry, sir. I am not following you. Could you repeat your question?

Chairman STARK. Well, the employers in Arizona have a cap on the cost of their payroll, with the exception of you and the cities and the counties and the school boards; they do not have a cap. And the question is whether or not that has any effect on the States.

Ms. RESNICK. Well, obviously a cap would have an effect on States.

Chairman STARK. No, no, there is no cap.

Ms. RESNICK. For some period of time, sir, but I believe it is to be phased in in the year 2002. So at some point, we will face that cap.

Chairman STARK. OK. You are willing to wait.

Ms. RESNICK. We would not like to wait a little longer, sir.

Chairman STARK. Are you familiar with what happens if you fail in a State, what the penalties are that are imposed at the Federal level?

Ms. RESNICK. If we fail to meet the specifics of the plan proposal?

Chairman STARK. Yes.

Ms. RESNICK. No, sir, I don't think that that is specific, what will happen when States are unable to meet the new terms of the program.

Chairman STARK. Well, as I read it, it is a tax or a premium or whatever they are going to call it on every employer in the State—15 percent tax on premiums to be used, I gather, for the Federal Government to then come in and run the alliances.

Ms. RESNICK. Yes, that is right. I stand corrected. You are right.

Chairman STARK. And the overhead costs. And as my colleague from Maryland says, you shouldn't fail.

Ms. RESNICK. We weren't planning on it.

Chairman STARK. Is there any reason the members of your association—I have often made the statement that—and you may be the person, the exception that makes it the rule.

I haven't found anybody yet, with the exception of a couple of people in the war room at the White House, who really want these mandatory State alliances. And I have often submitted that the plan works without them, that you just take one slice of baloney out of the sandwich, you still have a baloney sandwich. I mean, you could go ahead and have your managed Medicare-Medicaid problem that you do now; Maryland could continue to have its very excellent cost containment plan without this mandatory State alliance.

Now, is that something that has come up among the National Conference of State Legislatures as something they want?

Ms. RESNICK. Mr. Stark, the States have debated the issue rather significantly. As you know, there are a number of States that are doing very innovative health care programs that are not like this new proposal. However, States do want to retain the flexibility to try this program. We would like to be able to work with the administration to see if this can't be incorporated into current programs.

But we do recognize that there are States that are currently out there, as it were, on the end of a limb; and that they may not, in the short-term of their innovation, like Oregon, be able to incorporate the new administrative proposal on top of what they are already doing.

Chairman STARK. I am not sure I got the answer. I am talking about just the format of a State-wide alliance with, I presume, a board of seven who may not be providers, but could be the State.

But is this something that your group was looking for as a useful tool?

Ms. RESNICK. It is one of many strategies that the States have endorsed.

Chairman STARK. They have?

Ms. RESNICK. For their own States.

Mr. CARDIN. If the chairman will yield, if I understand, I think NCSL agrees with your position; they would like to have flexibility as to whether to use the alliances or use other methods.

Chairman STARK. Oh, I guess that was my question. I am talking about the mandatoriness of the alliance.

Ms. RESNICK. Yes, sir. The States want the flexibility to try not only this program, but other programs.

Chairman STARK. Let me say it another way.

Then they don't want the mandatory alliance designed the way it is designed in the plan; they want the option?

Ms. RESNICK. We would like the State option, yes, sir.

Chairman STARK. All right. That is what I thought. We are just saying the same thing in a different way.

But let me ask you this: If the bill were enacted in the fall of 1994, a year from now, what steps would the State of Arizona have to take to become a participating State by 1998?

Ms. RESNICK. Well, as you know, sir, Arizona, since it is testing out a managed competition kind of program on the Medicaid side, may be in a unique position to other States.

But presuming what you have set out, that 1994 is the date of passage and that the State has a couple of years to implement, it is quite possible that Arizona might choose to use its access administrative arm as the alliance, designated as such, create the board,

and fill that competitive component that moves into the private sector populations as well.

So we would begin to blend both the public and the private sector programs together under one alliance as it is described under the President's proposal.

That is not a system that would necessarily fit with other States.

Chairman STARK. And you would have to pass—would you have to pass any changes to your insurance code?

Ms. RESNICK. There would be the necessity to change some things within our insurance code, although we have moved forward on changing some pieces of the private sector insurance market regulation relative to small business, requiring smaller benefits package.

Chairman STARK. But you would have to eliminate medical underwriting and move to community ratings and eliminate commissions and insurance salespeople?

Ms. RESNICK. As if you were to incorporate the program as it is drafted now, those would be changes that any State would have to consider.

Chairman STARK. How would that sell in Arizona? How many votes would you have for that in the State legislature?

Ms. RESNICK. I don't know, sir.

Chairman STARK. You figure it would go through by unanimous consent?

Ms. RESNICK. I don't think it would be unanimous.

Chairman STARK. OK.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Thank you very much, Senator, for coming. I find it at least interesting that many people look at State legislatures and the folks who make up the State legislatures in an historical sense and do not look at those people who are there today facing very real problems and making decisions as the gentleman from Maryland indicated, the failure of the Federal Government to provide enabling opportunities for the States to make the decisions.

It may in part be because the gentleman from Maryland and this gentleman from California both served in the State legislatures, and I always like to require someone to walk a mile in someone else's shoes before they talk about folks doing or not doing what is or is not appropriate.

Some folks choose to come immediately to the Federal level, rather than to serve at the State level. I found the time that I served at the State level very rewarding. For example, trial lawyers are often pictured as someone who can stop anything. That may have been true in the 1950s or the 1960s or the 1970s. California recently finished passing and implementing what I consider to be landmark malpractice reform procedure that could very well be a useful model at the Federal level.

I only have to allude to the campaign finance legislation—which will soon be in front of another committee that I sit on and which appears to have every intention of passing this House—as to who is doing good work and to whether or not it is an honest response or a somewhat hypocritical response to what people perceive to be needed.

I know you have a difficult job, which is to represent the National Conference of State Legislatures and the position that they hold; sometimes it is difficult when you have a collection of folks from all over the United States to make narrow statements on issues, and so I would like to go back to your testimony to get a little better feel, if you could help me, for the executive resources of the national legislatures.

On page 3, you indicate that, in dealing with global targets, the States, not the National Health Board, should enforce them. Well, of course, that is not the way it is in the Clinton plan. And my assumption is, then, that you would not be in favor of the Clinton plan to the degree that the National Health Board establishes, implements and enforces a global budget. You believe that the States—and I agree with you—should have not only a role in carrying it out, but a role in developing and determining what the budget is.

Is that a fair extrapolation of what you have said here?

Ms. RESNICK. Yes, sir. But understand that the States would like to be able to work with the Federal Government, including the Congress, as it debates this issue to try to come to some consensus agreement on this particular proposal. But, yes, we are very concerned about that degree of regulation.

Mr. THOMAS. As am I, and I hope we can change it in that area. But the Clinton plan, as introduced, does not meet this particular concern.

On the alliances, you indicate that you want the Federal Government to develop broad guidelines and then let States determine the structure, function and governance of health alliances. I agree with you on that. I think you probably also will agree with me that the Clinton plan doesn't do that at the present time. In fact, the National Health Board approves a plan that the State offers; and if, in fact, the National Health Board doesn't like what the State thinks it needs, the National Health Board can say no to the State.

My assumption is then that, as introduced, your organization—and perhaps you yourself, as well—would have some problem with the structure. In fact, there has been great discussion about the role of the National Health Board and the way in which it controls the development, the approval, and in fact the very structure itself, while requiring States to deal with financing of the alliances. That is a great deal if you can get it, and I am sure you would like to preserve that role which says let the States deal with development, the structure, and let the Feds deal with the financing.

Am I putting words in your mouth, that that would be the preferred structure?

Ms. RESNICK. Well, you may be. It may be that individual members of NCSL would share your concern. I would only reiterate that we at NCSL are here to assist you in finding compromise on this very comprehensive program. There will be areas when we have much agreement with the proposal, and areas where we have some perhaps substantive disagreement. In those areas, we are here to work with you to try to find the most workable proposal.

Mr. THOMAS. By that artful statement, you aren't disagreeing with what the Clinton plan has introduced which imposes a State

structure on the States for the alliances approved finally by the National Health Board?

Ms. RESNICK. I think that I said that, yes, sir.

Mr. THOMAS. On the alliance boundary lines, we have some real concern—I do—about having the only preapproved alliance boundary being a consolidated metropolitan statistical area; and that health care needs based upon populations were never aware that they had to stop at the State line—especially in States like ours out west, and in other areas where significant portions of a State actually have a regional alliance which may not be toward either the major population center in the State or the capital of the State or where the major health resources are; and the reason they go to the regional alliance in another State is because that is a natural—if I can use that word—a natural direction to go for health care needs.

Do you know of any reason why the administration—you folks, I am sure, had input and discussed this with them—would set up an arbitrary State structure when it is so artificial in terms of the way in which health care is delivered in this country? Do you have insight on that?

Ms. RESNICK. Mr. Thomas, we did have numerous opportunities to discuss the proposal as it was being developed, and we did reiterate our position. From NCSL's perspective, it made no sense to arbitrarily suggest that one State should be the geographic region. There are multiple small States, including some southern States, who might be more comfortable with developing a more regional-based alliance, rather than a State-based alliance.

Mr. THOMAS. So the President's plan, as introduced, in terms of its rigid State structure, you are not as supportive of that as you would like to be. I share your concerns.

On page 7, you say you support a full integration of the acute care portion of Medicaid. The way I understand the President's plan is the Medicaid payments are going to be capped at 95 percent of their current rates, which means that within an alliance, within a State, you are going to have to raise the premiums elsewhere to cover or to subsidize that portion which otherwise would have been paid by Medicaid; and you are going to have to increase it automatically just like a tax because of the 95 percent coverage.

I know that you have talked about the taxes imposed in another section of your testimony and how you don't think they are fair. Have the State legislatures, or have you in terms of your involvement, especially in Arizona with the Medicaid—and we are working on that managed Medicare waiver as well, and it looks like it is going to be very successful, and we are going to get much more mileage out of the dollars than we have in the past—but do you have any concern about this cross-subsidy that goes on by government fiat within an alliance? Has there been any discussion among you folks about that?

Ms. RESNICK. As it relates to Medicaid, sir?

Mr. THOMAS. As it relates to only a 95 percent funding of the Medicaid costs, which means—

Ms. RESNICK. According to current costs.

Mr. THOMAS. Which means you are going to have to make up the difference within an alliance since the States are ultimately responsible for the finances within the structure.

Ms. RESNICK. Well, in Arizona, if you want to use that as an example, if we are only going to get 95 percent of what we are currently receiving for Medicaid services—understand that we receive less than we would have the opportunity to take if we were a traditional fee-for-service Medicaid State, so in fact it would be a cut to our State program.

Mr. THOMAS. So it is a cut on top of what others will be getting and would cause you some difficulty if, in fact, this National Health Board—alliance structure within a State, mandating the amount for Medicaid, is imposed on you and you have to adjust the figures to make the difference—

Ms. RESNICK. I believe it is a cost shift, sir.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. As I look at the Clinton proposal, I see three fundamental provisions in the Clinton proposal: universal coverage/employer mandates; cost containment/budget discipline; and then State flexibility to have diversity and to allow the plans to fit local needs.

I understand NCSL's view on State flexibility and I agree principally with your statements on giving the States maximum flexibility. Let me first start, though, if I might, with universal coverage, the employer mandates that are in the Clinton bill and try to understand NCSL's view.

If I read your statement and listen to your presentation here, you say on page 2 that the appropriate role of the Federal Government is to set national standards and to establish goals. Each State should be determining the best way to meet those goals. You say immediately before that, "we will actively oppose Federal preemption unless preemption is the only reasonable means of reaching a compelling national objective." And then you spell out that one of the objectives is universal coverage.

Now, there are only two feasible ways to get to universal coverage—one is through employer mandates, the other is through a single-payer system—and the bill gives States the opportunities to move forward on single-payer system if they want. Can I just determine from that that generally NCSL has no problem with the structure of the Clinton proposal as it reaches universal coverage, understanding of course the cost containments and State flexibility we need to talk about, but as we reach universal coverage, that that is consistent with NCSL's position?

Ms. RESNICK. Understand, Mr. Cardin, that NCSL represents 50 different State legislatures. There are States who believe that you can achieve universal coverage through a single-payer system. There are also States who believe that it is not necessary for an employer mandate to achieve the same result.

Mr. CARDIN. OK. And under this plan, if a State wishes to move forward with a single-payer option, they can?

Ms. RESNICK. Right.

Mr. CARDIN. If not, there will be every employer and employee paying part of the cost of health care?

Ms. RESNICK. Right.



Mr. CARDIN. If NCSL agrees with universal coverage, is there a third option or a fourth option that I am not aware of that NCSL supports as an option to get to universal coverage?

Ms. RESNICK. Well, again, Mr. Cardin, I think you need to recognize that there are States who believe that there are innovative approaches to universal care in their own States, given their own options and their own particular needs. So, yes, sir, I would have to say that there are States who believe that to be true.

Mr. CARDIN. What you might want to do is submit to us those other options that States would like to have that will guarantee universal coverage in their States; and I think there would be some interest on this committee to make sure that those options are available. I quite frankly don't know of any other option other than those two—

Mr. THOMAS. If the gentleman would yield.

Mr. CARDIN. I will be glad to yield to my friend from California.

Mr. THOMAS. There are a number of folks who are talking about reaching universal coverage through an individual mandate, either through employer or through the Tax Code by using vouchers or other arrangements. There is not an unlimited number of options; but the two that you have stated I think obviously and painfully leave out the individual mandate, which is a choice that a number of States believe to be the proper one.

Mr. CARDIN. I appreciate that clarification, and you are absolutely correct in that individual mandates are a third option. I don't believe it is politically feasible for a State to pass a requirement that every citizen in their State will have to pay the full cost of health care, maybe subsidized by the State. Knowing the States' limited resources, I would find that an unusual path for an individual State to charter, but if that is what a State would prefer, come forward with a proposal that you would like to see, the States' option on individual mandates, and we certainly will consider that.

The second basic approach then is cost-containment and budget discipline. And on your statement you say that NCSL has taken no position on whether budget targets should be established, but believes that if targets are established, States must have a role in developing those targets. And I agree with that statement.

You are not suggesting that if we have national budget targets and there are individual State targets within those national targets that the State would determine its own target. You are suggesting that working with the Federal Government, we would have fair targets among the various States. Is that a fair assessment?

Ms. RESNICK. Mr. Cardin, I think that our position is that States need a role in helping to establish the criteria, if there are to be targets, that would be used for those targets, and that those targets would have to recognize the differences between States and State population needs.

Mr. CARDIN. And I certainly agree with that.

Now, you believe that corporate alliances should not be exempt, the 5,000 or more employees. Of course, there is an interstate problem that becomes difficult, to deal with some of the larger plans. But you have not commented on the larger population that has been left out of the President's package on the alliances, and that is the Medicare population.

Has NCSL taken a position as to whether you believe it is fair for you to develop a system that excludes Medicare, or whether Medicare should also be part of your jurisdiction for covering health in your State?

Ms. RESNICK. Mr. Cardin, we have taken no formal position. I will tell you that there are a number of States who believe that, in fact, a universal system is just that, and all programs currently existing ought to be incorporated into the new so-called universal system.

Mr. CARDIN. I appreciate the fact that you would like to have the most inclusive part of your population in the plan, so you have the flexibility to develop and not see it compromised because people or companies can exempt, or groups can exempt, from the program; and I am pleased to hear your answer, because Medicare is a large group, and as long as they are outside of the main system, we are going to always have some problems of cost-shifting, which could really affect your ability to be able to control the overall health care of your State.

Mr. Chairman, thank you very much.

Chairman STARK. Mr. Thomas, did you wish to inquire further?

Mr. THOMAS. Yes. Back to the alliance structure, because the chairman has indicated he has some concern about whether or not they are needed, and that if this plan was presented by the President without the alliances, that the plan would be complete with a simple provision asking States to deal with the way in which it is administered.

I know you have to be artful in your answers, and I appreciate that. When you talked about the State global budget and that you wanted State input, it is obviously desirable, and everyone wants that to occur, but it is not required under the President's plan. What we are going to try to assure you, and I hope some of my colleagues on the other side are going to assure you, is that those people who have a frontline responsibility ongoing in attempting to do the best they can to meet the problem with the limited tools that the Federal Government has provided them, that you are going to have an ability to interact with whatever plan is created, not on a desirable basis, but on a required basis. And I agree with you that for some folk to maintain Medicare as a separate structure in the hopes that eventually we will move to a single-payer system and we will utilize that as the overarching architecture are really not committed to solving the health care problems in this round, because they ultimately want a second or a third round; and that any universal coverage access program we have should integrate all of the programs that we have available, or you are creating a kind of a Trojan horse in which you can compare unfairly an unreal program to a real-world program, perhaps to that unreal world program's benefit. I am going to do everything I can to make sure that all of those programs are integrated so that we have a maximum chance of survival.

In your discussions with the State legislatures, looking at the possibility of a federally-imposed alliance structure mandated within State borders, have you folks talked at all about strategy to change this? Are you planning on coming to us with examples of what has been done at the State level? I know in California we

have the voluntary HIPC structure, we have Calpers and some others, and although it may not be the tightly knit structure that the Federal plan recommends, over time it looks to have every possibility of succeeding.

Have you talked about bringing already presented regional structures across State lines as an example for us to show that, in fact, what we would be doing would be renting the fabric of a structure that already works if we impose the State structure? Have you folks talked about that strategy? Because frankly, the clock is ticking, and this is an area where I think there is real opportunity for fundamental reform if you people can bring to us examples of what is already working out there that can undermine this theoretical, mandated structure that doesn't conform to reality.

Ms. RESNICK. Again, Mr. Thomas, let me reiterate that the States prefer some degree of flexibility, some ability on the part of the States who wish to try an innovative approach to do so, and to give them sufficient time to see whether or not those approaches work. The examples you cited are all appropriate examples for that kind of position on the part of NCSL.

We are happy to work with you. We are here today to pledge our desire to work with you. But understand that the underlying concern at the State level is flexibility.

Mr. THOMAS. Thank you. On your final page summary, on page 12, you indicate that your goal to be active participants is to develop a comprehensive strategy based on four principles. One, universal coverage. My guess is that you agree with the President's plan in terms of providing universal coverage, but perhaps not necessarily all of the State legislatures would agree in the way in which they plan to implement it through an employer mandate.

Is that a fair statement?

Ms. RESNICK. Again, I reiterate my statement to Mr. Cardin, that there are States who may wish to go forward with an employer mandate and others who believe that they have other alternatives that would achieve universal coverage.

Mr. THOMAS. Your second principle is a strong role for States in program, design, and implementation under general Federal guidance, not dictate. My guess is that the President's plan falls short in that particular area, especially in the structure of the National Health Board, the mandating structure of the global budgets, and the mandatory State-structured alliance.

I will take the last statement reiterating the fact that the States, want equity for and between States. I think you might all be in a subservient relationship under the current structure, so I guess it produces uniformity; I don't know about equity. And then a firm fiscal foundation, I can assure you, a number of people are concerned about the reality of one meeting the cuts.

For example, the Medicare cut of \$124 billion over 5 years is only \$6 billion short of the entire budget for fiscal 1993 of \$130 billion. I am just amazed at the number of folk who don't react quite as strongly as they did under a former President when the basic thrust of saving \$124 billion over 5 years comes from reduction of those now famous words, waste, fraud and abuse, but swallow hard and argue that, in fact, we can move in that direction. I just don't believe that the structure for producing some of the moneys and,

in fact, the cross-subsidy structure mandated through the alliance arrangement with the Federal Government reneging on a portion of the funds which are far below adequate today, is one that promises a real, solid, fiscal—or a firm fiscal foundation.

So you don't have to say it, but based upon your principles, I think there is a fair and clear reading that unless we do some fundamental amending to the President's plan—and I believe that we are going to reach a point where, like some folks do in redoing old houses, that it is probably going to be better just to tear down the whole thing and rebuild a new one, rather than to try to take out the deadwood and replace it with some real good timber. You don't need to say it, but it is obvious that your statement indicates that the President's plan falls far short of the State legislatures' desires for universal coverage; and I appreciate very much your testimony.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Mr. Thomas, we have some wonderful old homes in Baltimore that I will take you by and show you.

Mr. THOMAS. And I would like to see the bill.

Mr. CARDIN. Housing in Baltimore is a lot cheaper than housing in California.

Let me ask NCSL if you would get back to us on whether the President's bill provides sufficient flexibility for the States to implement the various ways that you have used to try to get costs within certain goals. States have used alliances, States have used discounted rates, have used managed care, and have used regulated rate systems, including subjecting all payers to those regulated rates; and I would like to have your view as to whether the language in the President's proposal is adequate for you to be able to use any one of those tools or other tools that you may wish to use in order to reach certain goals on cost containment, whether those are available to you.

Sometimes as we put in national code, other objectives, such as health alliances or national policy objectives on interstate companies such as ERISA requirements, we prevent you from doing what you would like to do. So I would ask that you take on a role of looking at the bill and getting back to this committee as to whether you have sufficient flexibility in this statute for the States to use all of those various options that they may wish to use in order to keep costs within certain goals.

Ms. RESNICK. Mr. Cardin, I would pledge on behalf of NCSL to continue to provide any information that the Congress needs in order to debate this bill and to perfect this bill.

[The following was subsequently received:]



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STAFF CHAIR NCSL

WILLIAM POUND  
EXECUTIVE DIRECTOR

November 23, 1993

The Honorable Benjamin L. Cardin  
227 Cannon House Office Building  
Washington, D.C. 20510

Dear Representative Cardin:

This letter is in response to questioned posed to me on November 5, 1993, during my statement before the Health Subcommittee of the House Committee on Ways and Means regarding the role of states in the Clinton health plan proposal. You accurately pointed out that NCSL supports universal coverage, but has stopped short of endorsing an employer mandate as the method of reaching that goal. You also asserted that either an employer mandate or a single-payer system was the only way to achieve universal coverage. Your colleague, Congressman Thomas, added that an individual mandate was also a viable approach. I was asked to explore with you other options states may be interested in pursuing to reach universal coverage.

It is important to note that the method of paying for health care reform is a separate issue from reaching universal coverage. The implementation of an employer mandate or a single-payer system does not, by itself, guarantee universal coverage. An employer mandate, by definition, addresses individuals who are in the workforce. An employer mandate may, as the Administration's proposal does, also include the dependents of those individuals. However, an employer mandate must be accompanied by a program that provides coverage to individuals outside of the workforce. In addition, it may be necessary to impose an individual mandate to ensure universal coverage. A single-payer proposal may also probably need to be accompanied by an individual mandate to achieve universal coverage.

I say all of that only to emphasize that short of a social insurance program that everyone is required to participate in, universal coverage requires a number of requirements or techniques. Many states have enacted small group insurance reforms to improve the availability and affordability of health insurance coverage to employees of small businesses. Some believe that a combination of small group insurance reform, incentives to employers to provide coverage, low income subsidies and an individual mandate could go a long way to achieving universal coverage. Others believe that employer incentives are preferable to an employer mandate. We certainly have no consensus on these issues within our body at this time.

NCSL supports universal coverage. We also recognize and appreciate the fact that there are various ways of achieving the goal. We must analyze each health care reform proposal as a package, balancing our support for universal coverage with our other goals. We also want to work closely with both the Congress and the Administration to develop a compromise.

Finally, I was asked if the Administration's proposal provides states with sufficient flexibility with respect to cost containment. The structure of the Administration's plan is likely to play an important role in determining whether states will be able to contain costs. The rules regarding the size and boundaries of the regional health alliances, for instance, have the potential of making or breaking a state programs.

The effectiveness of the regional health alliances is dependent on: (1) whether or not they have sufficient negotiating strength to be competitive with the corporate alliances; (2) whether the census of the regional alliance is able to draw a sufficient number of participating plans; and (3) whether the subsidies to small businesses and low income individuals are available to ensure payment of premiums. There are also specific restrictions on rate regulation. States are precluded from regulating rates unless they do so on a statewide basis. We do have some concerns regarding the states' ability to contain costs under the proposal.

I thank you for this opportunity to share some additional thoughts with you regarding President Clinton's health care reform proposal. I look forward to working with you on these issues in the coming months.

Sincerely,



Cindy Resnick  
Minority Leader  
Arizona State Senate

Ms. RESNICK. More importantly, I would ask of all of you, if you would continue to keep us involved as well. We would like to assist you in this effort.

Mr. CARDIN. Thank you.

Chairman STARK. I will take you up on that now, Senator. Let's talk for a minute about the mandates, whether they are employer or individual, because I think that is going to give us all a bit of angst.

As you are aware, last month Oregon, which arguably is a somewhat more liberal State than the State of Arizona—

Ms. RESNICK. Just a bit.

Chairman STARK. Just a bit.

—repealed its mandate.

Ms. RESNICK. Yes, sir.

Chairman STARK. And to my knowledge, there is no State in the country that currently has a mandate. Close in Hawaii, but it is still not universal coverage. It is my sense that that is going to be a tough vote in a lot of States.

I don't care whether it is individual, and I would just ask you for instance, first of all in Arizona, what is the upper house in numbers? How many State senators?

Ms. RESNICK. Thirty.

Chairman STARK. And how many in the minority?

Ms. RESNICK. Twelve.

Chairman STARK. Of the 12, how many votes could you get for a mandate?

Ms. RESNICK. In Arizona, sir, I think it might be a difficult sell.

Chairman STARK. Even on your side of the aisle.

Ms. RESNICK. Even on my side of the aisle.

Chairman STARK. I think the same thing is true in California, where the Democrats are in marginal control of the houses. And then what happens—and I just want to go back on this—the Secretary puts the mandate in place. The Federal Government—if you can't vote for a mandate, I don't care whether it is individual, the way the bill reads is the Secretary comes in and places a mandated premium on every employer in the State, plus 15 percent for good measure for overhead and punishment and whatever else.

Now, knowing that, on the 11 members that you have to ride herd over in Arizona, how many of those could you scare into coming across and saying, well, I guess we had better have a mandate or it is going to be shoved down our throat. Is that the way to go?

Ms. RESNICK. Mr. Stark, just as an example, Arizona is currently going into special session on air quality where it is suggested unless the Feds have a particular position relative to a mandate, it is under great resistance in the legislature, sir; so—and it is a situation where—

Chairman STARK. Is it a closed session, I imagine? With NAFTA, they might want to join Mexico.

Ms. RESNICK. It is a thought, sir.

Chairman STARK. Well, I think I have made my point, and it would help. I gather that your conference has not endorsed mandates.

Ms. RESNICK. No, sir, we have used it as one strategy. Again, there may be States who prefer that particular strategy.

Chairman STARK. Well, OK. The President's bill requires mandates, and while that may be changed or you may be given options, what would be helpful to us is a clearer assessment of the reality of some kind of mandate being passed by the States. I don't care whether it is personal mandate, or I don't care whether it is an employer mandate, if we don't have that, and/or single-payer.

Now, in Vermont they say we are going to go single-payer. All right. Out of the remaining 49, I guess I would ask my friends from Hawaii, what do you think the chances in Hawaii are of extending that mandate to part-time employees and the unemployed, tourists. Not illegal tourists. I mean, I always fill out that card that says I don't have any fresh fruit when I get off the airplane, so I presume that I am not an undocumented tourist when I get to Hawaii.

I would like to know. I personally don't think half the States in the country will pass that.

Ms. RESNICK. Mr. Stark, it is always my sense that as a parent, when working with children, it is better to encourage good behavior than to penalize.

Chairman STARK. I hope you get better results with your children than I did with mine. They always threatened to hold their breath and turn blue and die if we didn't cave in; and unfortunately, none of them was successful.

Listen, thank you very much. It would help us for your association—because there is no sense us getting into all of the problems of providing you with some kind of mandate and saying, you must pass it, when you are willing to come back and say in all seriousness and show us that the States aren't going to do that.

And then let's find something that, in a realistic assessment, we can say together, the States are very likely to do this.

That is my concern, is being realistic of what we think the States will accomplish—not what they should; that is more up to them.

[The following was subsequently received:]





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STAFF CHAIR NCSL

November 23, 1993

The Honorable Fortney "Pete" Stark  
239 Cannon House Office Building  
Washington, D.C. 20510

WILLIAM POUND  
EXECUTIVE DIRECTOR

Dear Chairman Stark:

I appreciated the opportunity to testify before your subcommittee on the role of states in President Clinton's health care reform proposal. This letter responds to a question you posed regarding the ability of state legislatures to enact an employer mandate.

The employer mandate issue is controversial nationally and within the fifty states. The major difference between the two levels of government is the environment. We cannot forget that even when a state enacts an employer mandate, the state cannot implement that program due to the federal Employee Retirement Income Security Act (ERISA), that precludes such action. So your question regarding whether states can enact an employer mandate is a question about enacting a controversial requirement in a hostile environment. Even so, some states have enacted an employer mandate. Hawaii, Oregon, and Washington have enacted an employer mandate with respect to health insurance. The Oregon law, originally enacted as part of a package of bills designed to move the state toward universal coverage, is an employer mandate that will trigger into effect if the state fails to insure a specific number of individuals employed by small businesses by the date set in statute. The trigger date has been delayed a number of times, most recently this past summer. The current date is January 1, 1997 for businesses with 26 or more employees, and January 1, 1998 for businesses with 25 or fewer employees.

Washington State enacted its comprehensive health care reform program earlier this year. The state's comprehensive reform initiative has many components in common with President Clinton's proposal, including an employer mandate. Finally, Hawaii has had their mandate on the books since 1974, but implementation was delayed until the state was finally granted a limited ERISA waiver in 1983.

It is possible that more states would pursue an employer mandate if the Congress began granting ERISA waivers. But that is totally speculative. We can say that states can and have enacted employer mandates.

I hope this information proves helpful to you and your staff. I look forward to a continued dialogue on health care reform.

Sincerely,

*Cindy Resnick*

Cindy Resnick  
Minority Leader  
Arizona State Senate

Mr. THOMAS. Mr. Chairman.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Very briefly on that point, because in the original explanation of the President's plan prior to the introduction of legislation, the section dealing with the States' failure to legislate the proposed arrangement was that the Federal Government would impose a cost on the employers in that State sufficient to cover the cost of the program and the overhead.

In the legislation, it says that the Federal Government will impose a cost on the employers of the State to pay for the program, plus an arbitrary fixed 15 percent, which sounds more like the mandated requirement to do it than the encouraging arrangement.

So it is interesting that within the war room of the President's health care gurus, between the original proposal released to the press and the legislation, they have, instead of actual overhead costs, put in a 15 percent fixed penalty—punishment, if you will—if you don't follow the mandates that are in the structure.

Is this moving in the direction that the State legislatures thought the working arrangement would be, or is it moving away from the direction that the State legislatures thought or hold desirable?

Ms. RESNICK. Well, again, Mr. Thomas, I would reiterate that NCSL prefers some degree of flexibility. We understand this particular proposal's desire for us to incorporate one particular road to universal coverage.

Mr. THOMAS. And punish you at 15 percent if you don't.

Ms. RESNICK. We—I would suggest to you that most States would decline the punishment, sir. Thank you.

Chairman STARK. I want to thank you, Senator, very much for your help; and I do hope that we can continue to work with your organization as we wind through this legislation for the next year or so. Thank you very much.

Ms. RESNICK. Thank you, Mr. Chairman.

Chairman STARK. Our next witness will be Ray Scheppach, who is executive director of the National Governors Association.

I would like to welcome Mr. Scheppach to the committee and ask you to proceed to summarize your testimony or expand on it in any way that you are comfortable.

#### **STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION**

Mr. SCHEPPACH. Good morning, Mr. Chairman and Members of the subcommittee. I appreciate the opportunity to appear before you on behalf of the Nation's Governors to discuss the role of States in health care reform.

I will summarize my statement quickly and focus on two issues: First, what is the appropriate State role in health care reform; and second, what is the Governors' reaction to President Clinton's health care reform plan.

Let me be clear at the outset, Mr. Chairman, that Governors do not want to have 50 different State programs. Governors want portability of health care benefits from State to State and are extremely sensitive to the concerns of large multistate employers. It

is for these reasons that the NGA supports a strong Federal framework.

That framework includes, first, the enactment of Federal legislation to eliminate medical underwriting and establish community rating; second, a national benefit package that is required in all States; third, Federal malpractice guidelines that States can follow; fourth, changes in Federal antitrust legislation; and fifth, medical outcome and quality information standards.

Not only are these elements of a strong Federal framework; they also preempt State authority in a number of important areas. Nevertheless, they are necessary to develop an efficient delivery system for health care.

The other major component necessary for efficiency is that States need to have the flexibility to administer this program on a day-by-day basis within this Federal framework. Essentially, this means flexibility in designing, regulating and overseeing regional alliances and the accountable health plans.

The following are some of the advantages for a State-based program:

One, States are large enough to gain economies of scale and yet small enough to tailor the system to the unique needs and the culture of individual States;

Two, since the new system will require us to move into uncharted waters, it is critical to allow for State innovation and experimentation, to design the most efficient system. This also allows for mid-course corrections and adjustments without the requirements of Federal waivers or changes in Federal legislation;

Three, given the implementation of a new health care system will take 3 to 5 years, it is critical that a sustained commitment in support of health care reform be maintained at the grassroots level. Allowing State flexibility to accommodate and adjust to local concerns will help maintain that long-run commitment.

Finally, States already have significant experience in administering health care programs such as Medicaid, State employers health care, as well as insurance regulation and regulation of providers. It is critical to build on this expertise.

With respect to the Clinton plan, Mr. Chairman and Members of the subcommittee, the Governors support the State-Federal partnership that is incorporated into President Clinton's plan. It provides a strong Federal structure that is essential for true reform, yet provides ample flexibility for the States to develop and implement a delivery system that will work in both urban and rural settings and under diverse socioeconomic conditions.

With respect to the alliances, the Governors support the fact that the States will have the ability to determine the number of alliances, the regional boundaries, the appointment of the Board members, and the legal entities, be it a nonprofit or a State agency. They also support the fact that they are able to either do the right regulation for those providers that are outside the alliance on a State-wide basis or in fact vest that within the alliances themselves.

Governors also appreciate the flexibility of a singer-payer option described in the act.

Finally, they also support having jurisdiction over the accountable health plans in terms of guaranteed funds, audit functions and general oversight.

In the area of premium caps, there is some concern. As you look at the legislation right now, it seems to indicate that States are responsible to ensure that everybody gets health care. If you combine that with fairly tight budgets and the fact that guarantee funds may not be sufficient in case some accountable health plans go under, then it seems that States could, in fact, be held accountable in that particular area.

With respect to the transition to the new system, we are very pleased with the administration's proposal. If you look at that, there is about a 2½ year window in which States can come into the system. This will allow States that are ready, such as Florida, Oregon, Washington, Minnesota and some others, to in fact go into the system within the first 6 months; while other States that need more time to get ready will be allowed to come on at a later time.

There are significant financial incentives for States to go into this system early: Number one, there is planning money available to all States; number two, there is a sufficient amount of start-up money available to States; and third, States have substantial financial incentives, because when they trigger on, the Federal Government will provide both the low-income subsidies as well as the subsidies for small business, which can be a significant injection of income into individual States that go into the system early on.

Just one final comment about the community-based, long-term care program. Although the Governors have some concern about having some responsibility in this area, I think the structure of the program makes a fair amount of sense, since it is not individuals who are entitled; it is, in fact, the State that is entitled. So although it is a capped entitlement, it is very dissimilar to the Medicaid and Medicare, which are essentially entitling individuals.

Mr. Chairman, I would be very happy to answer any questions. [The prepared statement follows:]

## Statement of

**Raymond C. Scheppach, Ph.D.**  
**Executive Director**  
**National Governors' Association**

Good morning Mr. Chairman and members of the subcommittee. I appreciate the opportunity to appear before you today on behalf of the nation's Governors to discuss the role of states in health care reform.

In this statement I would like to summarize three major issues.

- The Governors' health care reform policy;
- The appropriate state role in health care reform; and,
- The Governors' reaction to President Clinton's Health Security Act.

#### **THE GOVERNORS' HEALTH CARE REFORM POLICY**

Last February, the Governors adopted a comprehensive policy on national health reform that calls for universal access to quality and affordable health care. The policy supports a national health care system that recognizes the importance of federal uniformity in health reform but at the same time recognizes the essential roles and responsibilities of states in the administration and delivery of health care. The Governors support a framework that includes managed competition; a national benefits package that includes primary and preventive care; guaranteed issue and portability of coverage to end the discriminatory insurance practices that are used to deny coverage; tort reform; antitrust changes; administrative simplifications; and the development of national health outcomes so that Americans can assess the efficacy of their health care. The policy also calls for purchasing cooperatives at the state level.

The Governors believe that strong cost control systems are integral to any health care reform system adopted for the nation. The Governors chose not to endorse enforceable budgets from the outset, preferring budget targets in the early years. They reasoned that setting enforceable budgets for one-seventh of the American economy requires a stable and objective national data system. Such a system does not now exist. Thus, the premature setting of budgets could have some unintended negative effects. And while it is not the subject of this hearing, the Governors call for major reform of the Medicaid program so all current Medicaid recipients would receive their acute care coverage through purchasing alliances.

#### **THE APPROPRIATE STATE ROLE IN HEALTH CARE REFORM**

Let me be clear, Mr. Chairman, that Governors do not want to have fifty different state programs. Governors want portability of health care benefits from state to state and are extremely sensitive to the concerns of large multistate employers. It is for these reasons that the NGA supports a strong federal framework that includes:

1. The enactment of federal legislation to eliminate medical underwriting and establish community rating.
2. One national benefit package that is required in all states.
3. Federal malpractice guidelines that states will follow.
4. Changes in federal antitrust legislation.
5. Medical outcome and quality information standards.

Not only are these elements of a strong federal framework, but they preempt state authority in a number of important areas. Nevertheless, they are necessary to develop an efficient delivery system for health care. The other major component necessary to develop an efficient system is state flexibility. States need to have the flexibility to administer the program on a day-to-day basis within this federal framework. Essentially, this means flexibility in designing, regulating, and overseeing the regional alliances and accountable health plans. The following are the advantages of a state-based system.

- States are large enough to gain the economies of scale and yet small enough to tailor the system to the unique needs and culture of the individual states.
- Since the new system will require us to move into uncharted waters it is critical to allow for state innovation and experimentation to design the most efficient systems. This also allows for mid-course corrections and adjustments without the requirement of a federal waiver or changes in federal legislation.
- Given that the implementation of a new health care system will take three to five years it is critical that a sustained commitment in support health care reform be maintained at the grass root level. Allowing state flexibility to accommodate and adjust to local concerns will help maintain that commitment.
- States already have significant experience in administering health care programs, such as Medicaid and state employees' health care, as well as insurance regulation and other regulation of providers. It is important to build on this expertise.

I would like to note, however, that while there is significant agreement among the Governors on the state role in national health reform, they do not agree on all aspects of the President's plan. Most notable among these issues is the President's strategy to finance the new system.

### THE GOVERNORS REACTION TO THE PRESIDENT'S HEALTH SECURITY ACT

Mr. Chairman and members of the subcommittee, the Governors support the state/federal partnership that is incorporated into President Clinton's plan. It provides the strong federal structure that is essential for true reform, yet there is ample flexibility so that states can develop and implement a delivery system that will work in both urban and rural settings and under diverse socioeconomic conditions.

**Alliances and Accountable Health Plans.** The Health Security Act gives states discretion on the number and regional boundaries of alliances. This will enable individual states to consider how its provider community and local governments are organized. The Governors support such latitude but still have some questions about one aspect of this provision. The act does not permit metropolitan statistical areas to be divided into different alliances. As we understand it, the policy was designed to preclude discriminatory practices in drawing alliance boundaries. We support the antidiscriminatory language in the act and, if necessary, would support stronger language to give states the broader flexibility at issue. However, at the very least, there should be a waiver provision to allow the division of metropolitan statistical areas. Our concern is that it may be important in some states to draw boundaries that include rural areas with a part of the SMSA. This may increase the quality of care that is available in rural areas. Finally, the Governors support the flexibility to decide the legal entity governing the alliance (i.e., state agency, quasi-governmental agency, or private nonprofit organization).

The Governors support the flexibility of the single-payer option described in the act with one modification. The act requires the single-payer system to be operated by the state or a designated agency of the state. The Governors prefer to be able to contract out all or parts of a state's operation to the private sector and would like the legislative language to specifically allow this option.

The Governors also support the authority vested in states to certify accountable health plans (AHPs) as well as to oversee the audits and guarantee funds. Although every state has had experience in provider enrollment and certification as part of Medicaid, not all states have had extensive experience with larger plans. We believe that cooperation among states and between states and the federal government during the transition to the new system will enable states to perform this function. It is critical that states have authority over both the alliances and the AHPs.

While giving states flexibility in the establishment and administration of health alliances and AHPs, the legislative text confuses lines of authority between the federal and state governments by giving both the federal government and states some direct oversight and regulatory control over these entities. This could dilute accountability and may hurt the administrative efficiency of the system. Although the federal government has a legitimate interest in the efficient and effective operation of alliances and AHPs, the interest is best expressed through direct oversight of state

governments, which can then regulate and oversee alliances and plans. We suggest that the federal government provide appropriate general guidelines rather than direct oversight.

While Governors may differ on the need for setting fee-for-service rates they appreciate the ability for states to set rates for the entire state or to have them vest this authority in regional alliances, as appropriate.

Finally, there is some concern about the responsibility of states to ensure adequate access to a choice of health plans, as described in the act. The language calls not only for choice, but also for access to plans at or below the weighted average premium "to the maximum extent practicable." The availability of plans will, to some extent, be determined by the premium budget assigned to the alliance and the number of AHPs that choose to bid within that budget cap. Because states will have no control over the budget that will be set nationally, states will not have the tools to ensure choice. Moreover, the act stipulates a right to enforce state responsibilities through 42 U.S.C. 1983 that is quite onerous. We suggest that the state responsibility for access language be deleted from the legislation.

**Premium Caps.** As I said earlier Mr. Chairman, the Governors' policy supports budget targets in the early years of national reform rather than immediate enforceable premium (budget) caps as detailed in the Health Security Act. Although the cap is determined and enforced by the federal government, the impact on states may be direct. If the federal government fails to set reasonable limits in the first several years, states will be left with the responsibility for correcting the damage done to providers, networks, and the availability of health care. The Governors urge caution in setting premium caps in the early years of health reform. While urging caution, the Governors do support the provision in the act that gives financial incentives to states to try to bring the alliances in under budget. Without this incentive, one can expect that each alliance would negotiate premiums that are equal to the premium cap set by the National Health Board.

**Transition to the New System.** States may begin implementing the new system as early as January 1, 1996, with all states participating within two years. Although this deadline is somewhat ambitious, Governors believe that it can be met with the additional planning and start-up funds detailed in the legislative text. In fact, some states would prefer to begin operating a national system before the 1996 start date.

Currently, a number of states are establishing voluntary alliances, and others will be considering such legislation next year. These states will serve as laboratories for the President's approach, and other states will be able to benefit from their experiences. Essentially, the two-year window will allow states such as Florida, Hawaii, Minnesota, Oregon, Vermont, and Washington to implement early, since many of them already have enacted major health care reform. Similarly, it will give other states more time to implement. It is important to have the planning and start-up funds in the proposed legislation. States will have strong incentive to implement early since they will receive low-income and small business subsidies when they trigger on the new system.

**New Community-Based Long-Term Care Program.** The act creates a new community-based long-term care program for persons with significant functional impairments. The Governors support community-based alternatives to institutional care, and the act has several provisions, including this one, consistent with that position. And, while the Governors support community-based long-term care, the financing of this new program raises some concerns. Specifically, federal participation, though significant, is limited, while the state financial exposure may not be. In general, we believe that issues related to community and institutional long-term care need greater consideration by Congress either as a part of national reform or separately in the near future.

## CONCLUSION

Mr. Chairman and members of the subcommittee, as you well know, the legislative text of the President's plan is more than 1,300 pages in length. The testimony given before you today is based on our first review of the plan. The devil, however, is always in the details and we continue to examine the language. Over the next several weeks, as additional issues arise, we will be sure to keep you informed.

Finally, after too many years, the nation appears ready for meaningful national health reform. The nation's Governors support reform that provides universal access to quality and affordable health care. Moreover, the Governors strongly believe that states must have an integral role in any reform strategy. The Governors look forward to working with each of you as you begin to craft the final legislative package. Working with its sister organization, the National Association of State Budget Officers, the National Governors' Association is gathering information on the state fiscal impact of the Health Security Act. As summary data becomes available, we will make that information available to you for your deliberations.

Thank you for the opportunity to appear before the subcommittee today. If you have questions, I will be glad to answer them.



Mr. THOMAS. Thank you very much, Mr. Scheppach. You have once again a very artfully crafted statement. My assumption is that where you mentioned areas that you agreed with the President's plan, those are the areas of agreement.

Where you didn't mention them, those are areas of disagreement? Is that the way I should read this?

Mr. SCHEPPACH. The Governors have concentrated on the Federal-State partnership. That is where we have a strong consensus and we think that is where we need to enter the debate. So in other areas, such as general financing and so on, where we had substantial differences, we did not try to get a consensus.

Mr. THOMAS. All right. On page 1, am I supposed to read literally what is written here, or am I supposed to interpret where it says, "Last February, the Governors adopted a comprehensive policy on national health reform that calls for universal access to quality and affordable health care." Does that mean universal access?

Mr. SCHEPPACH. Yes, it does.

Mr. THOMAS. The President has universal coverage. So the Governors are in disagreement with the President's plan where he mandates universal coverage. Well, we need to get clear on this, because there is a war going on up here over access or coverage. The President mandates coverage, and if someone falls short of that, they are absolutely pilloried by virtue of not supporting universal coverage.

I believe universal access is the only intelligent way to go, over a short period of time, to promote the opportunity for States and lesser units to participate in the system. If you are going to argue it is universal coverage mandated from the Federal Government, imposed with stiff penalties if you don't follow, then I don't see a role, a real role for States or lesser units of government.

I see here the word universal "access." Was that a mistake, or do you mean universal access?

Mr. SCHEPPACH. I think it means access that does not preclude universal coverage. The Governors did not take a position on the major question here, which is financing, whether that is a personal mandate or an employer mandate or a single-payer system. They were unable to do that.

Mr. THOMAS. I agree with the Governors' statement in support of universal access. You didn't say universal coverage.

The President's plan says "mandated universal coverage." So the Governors don't agree with that portion of the plan as a group; is that correct?

Mr. SCHEPPACH. Let me say that they agree with access; they do not oppose coverage.

Mr. THOMAS. This is helpful in trying to make real decisions here on what we do or not do, because that is going to be a key, cutting-edge question.

Let's try it again on page 3, where you say, "the Governors support the State-Federal partnership that is incorporated in President Clinton's plan. It provides the strong Federal structure that is essential for true reform, yet there is ample flexibility so that States can develop and implement a delivery system that will work in both urban and rural settings and under diverse socioeconomic conditions."

Are you aware that the National Health Board under President Clinton's plan has the final say on any plan that a State proposes and can in fact, and does in fact, have the power to reject a State's plan?

Mr. SCHEPPACH. Yes. I am very aware of that. We had numerous discussions with the administration on that issue.

Mr. THOMAS. And the Governors support the ability of the National Health Board to reject a plan, devised, structured and supported by the State?

Mr. SCHEPPACH. We don't have a specific policy on that, but I think the Governors are comfortable with a group being able to review a State plan for consistency with respect to the legislation.

Mr. THOMAS. So they have no problem with a federally-controlled mandated structure, because that is really what it is. It is the final approval of the National Health Board of any plan offered by a State.

Mr. SCHEPPACH. Well, you are talking about "mandated" again. We don't have a position on that. They are comfortable with an arm of the Federal Government reviewing a plan to ensure that it is consistent.

Mr. THOMAS. Not reviewing it, having final say and the ability to reject and impose their own plan.

Mr. SCHEPPACH. Well, my sense is that the legislation, as it is written, gives States a lot of flexibility in that particular area, and that States would come in consistent with the legislation; and if that is true, it seems that the Board would be in fact required to sign off on the plan.

Mr. THOMAS. There is no requirement that the National Health Board sign off on anything. What they have is the full and complete final power to say yes or no. If you are going to lead the Governors into a wishing-and-hoping position as to what may or may not happen with this National Health Board's malevolence in allowing you to participate in this structure, then let me introduce you to the legislative process.

If it doesn't say that, if it doesn't say that you have to come to a mutual agreement, if it doesn't give you some participatory role, other than supplicantly offering up a structure over which they can then have total control, I find your statement on page 6, one which, again, when I read between the lines, indicates that maybe as this process goes forward and you folks begin to see the final outline as to what is really going to happen, you might firm up a little bit and begin to have a little backbone in your statements.

It says on the bottom of page 6, "Specifically, Federal participation, though significant, is limited, while the State financial exposure may not be." That is a real cute statement. But I believe it to be the essence of what is going on here, and that is, you folks are going to wind up holding the bag. It is the State that is going to be financially responsible in the structure that is currently being offered, and it is the Federal Government that is going to be able to basically dictate the plan and the way in which it operates. That is the fundamental financing mechanism throughout this structure.

And although this statement appears to be very artfully crafted and almost cute in its essence, I think the Governors need to get serious about the fundamental role that is going to be played under

the President's plan in terms of the Federal Government dictating, and not funding; and that the States are responsible for the funding.

I am hopeful that the next time the testimony is presented—and I hope there is a next time as we move forward with this—that you people begin to realize that under this plan, the States are going to be fundamentally financially obligated, and you are not going to have the ability to control your own destinies. The Federal Government will mandate and the States will fund.

Chairman STARK. Mr. Cardin.

Mr. SCHEPPACH. Let me just say, Mr. Chairman, I raised that point in the testimony because we are concerned about that. As I said, for all practical purposes the global budgets are a ceiling on spending; for all practical purposes the benefit package is a floor. And although there is a fair amount of Federal financing, where you potentially get into a problem, I think, is the combination of a tight budget, not enough money in guaranty funds, and the fact that the State governments are held accountable for ensuring access. That is a real concern.

I think that the language in the bill, as it is presently drafted—and this also deals with the other issue, which is the overall cap and entitlement—is unclear at this time and needs to be made clear.

Chairman STARK. The same box that it puts the insurance companies in—a cap on the revenue, a floor on the benefit that they have to provide—and it is up to them to squeeze in the middle.

Mr. SCHEPPACH. Well, except the legislation is very clear that they are forced to go back and take similar amounts of money from the providers.

Mr. THOMAS. There is no ambiguity about the fact that the National Health Board, after the statutory setting of the health benefits by the Congress, will have complete control over what those benefits are—so once again, dictation from the Federal level, paid for somewhere else.

Mr. CARDIN. Mr. Scheppach, let me thank you very much for your testimony, and also thank you for the role the National Governors Association has taken in the development of this legislation, and your focus here today.

I think you are absolutely correct, that the Governors can add a great deal to the quality of the national debate by concentrating on the partnership between the Federal Government and the State governments. And that really should be the principal focus for the nation's Governors. So I thank you for that.

You mentioned in your presentation that you are satisfied with the general flexibility given in the States being able to manage their health care systems within the general costs that have been provided here. You may disagree with those costs or how they are determined, et cetera.

I would like you to focus in on and get back to us as to whether there is ample flexibility here for the States to develop the type of rate-setting systems that they may want, that you refer to in your statement, or the other ways that they may wish to use in order to get costs under control.

There are many different systems being used throughout the country, some very effective. My own State of Maryland, we have a system of an all-payer rate system for hospital care. And I think there is some concern as to whether the language is broad enough to allow States to continue these types of rate-setting, considering the language here that deals with alliances and with the competitive process.

So I just would ask that you scrutinize carefully the language in this legislation—and feel comfortable to respond now; that is fine—but if you want to get back to us, please do, to make sure that your oral statements are consistent with the language that was finally presented in the bill.

And then last, if would you watch us as we go through the legislative process to make sure that what we do is consistent with the goal of our Governors, to have the flexibility to implement this national system.

Mr. SCHEPPACH. In general we are relatively comfortable. For example, the alliances can be price sticklers or negotiators. I think they have adopted sort of the Minnesota model, that what they are trying to do is to force networks, by doing rate regulation outside the networks and doing capitated rates inside the networks. We will look at it again in terms of, are there areas that we need tools in order—for budget control, and we will get back to you.

But I think the broad framework makes a certain amount of sense from our standpoint.

Mr. CARDIN. Thank you.

Chairman STARK. Just to come back within all of this, Mr. Scheppach, because it does raise some problems for us. Is there anything that would be inconsistent with the Governors' position if we removed these alliances from the package? I guess that would have the effect, if the State is then responsible, it could create an alliance if it chose; or the State government, that could become the alliance. Do you see anything in there that is particularly essential to the Governors?

Mr. SCHEPPACH. Yes, I think, Mr. Chairman, that the Governors tend to support alliances. And one of the reasons that they do is that they want to bring the acute care portion of Medicaid into an alliance.

Chairman STARK. They can do that now.

Mr. SCHEPPACH. No, no, you can't.

Chairman STARK. Yes.

Mr. SCHEPPACH. No, no. Only about 8 percent of the Medicaid population can be brought into managed care. You need a waiver to do that.

Chairman STARK. Let's assume that the waiver was—

Mr. SCHEPPACH. Oh, OK. It would take more than just a waiver; it would take changes in Federal legislation. Arizona is one of the very few States that has the ability.

The problem with alliances is that you have to get alliances of sufficient size in order to get around the risk adjustment problem. When you have a whole bunch of small alliances, you may get back into the same situation you have now of cherry-picking.

Chairman STARK. But is there anybody in your association or among the Governors who believes that we know how to risk ad-

just? I mean, we have had testimony after testimony after testimony, and nobody knows how to risk adjust.

Mr. SCHEPPACH. The only thing I can say is that if you go into community rating and everybody is paying the same amount, then you are forced to adjust on the other side. You just are forced. Whether you have 15 alliances or one, you are going to be forced to—

Chairman STARK. I guess what I am saying is that there is no one, at this point—and in good faith, I am not suggesting that I am criticizing a risk adjustment plan. I think I can state without any fear of any contradiction from the academic community or regulatory community or NIAK, risk adjustment as a procedure or as a methodology does not exist. And that is one of the problems we keep facing.

Now, we could do it retroactively, but that is nothing but cost reimbursement.

Mr. SCHEPPACH. But you would have to agree with me, Mr. Chairman, that it gets more difficult, the smaller the alliance. To agree with you and your single-payer approach—

Chairman STARK. It is impossible any way you slice it.

Mr. SCHEPPACH. But what I am saying is, if you have a smaller number of larger alliances, it doesn't matter as much. When you have a large number of small alliances, it is a much more difficult problem.

Chairman STARK. My concern—I would go further than that, and it is another item I wanted to bring up. If you have more than one alliance—and I notice in your testimony there is some question about being able to divide SMSAs to bring in rural. What I see is the opportunity, quite frankly, to gerrymander. And how States would choose to do that or what the political pressures would be to do that I think would be severe.

I mean, you can judge that in different States. But the determination of the alliance boundaries could very well determine the fiscal health and the quality of a plan. And you and I could speculate on all kinds of different States. It just seems to me an area for both dispute and/or mischief, which to some extent is eliminated if you just say I am sorry, a big State, California, New York—might have a good reason to come back and say we would like to divide the State into two regions or three regions; and it could then be reviewed from the standpoint of discrimination, cost experience and so forth.

But I don't really know why the Governors want to get into the, in a sense the redistricting, if you will, when they already have to do that once every 10 years. I don't say that with prejudice to either side. I am just saying it has quite escaped me.

First, a plan had to serve the whole alliance. Then we had a statement in the revision that a plan within the alliance could pick its geographic boundaries within the alliance. If that isn't redlining and a definition for it, I haven't heard it.

I mean, as I say, those are technical problems, and I would just encourage the States—and I would encourage it in the bill—to say one alliance is quite enough, thank you; and you have to show me why plans shouldn't be encouraged to cover pretty broad areas. That is an issue that the States will have to face.

Mr. SCHEPPACH. One of the driving forces is how is the industry presently organized. How is the provider community providing services? And I really think that that is going to be key, and I would suspect—

Chairman STARK. On a very discriminatory basis.

Mr. SCHEPPACH. Well, I mean I think—

Chairman STARK. My favorite HMO in the whole world, 50 percent of the people in the county I represent, 600,000 people, has been there 50 years, probably one of the best HMOs in the country; and the only reason it survives is that it has done nothing but cherry-picking. I mean, Kaiser has never reached out, never had to, and I don't blame them.

But what I am suggesting to you is that the way the insurance is delivered today is discriminatory.

Mr. SCHEPPACH. There is a very strong incentive on the part of Governors and State legislators, because they want to bring the Medicaid population into the alliance, which is generally from low-income areas, and to include these with a large enough risk pool. So I think they have a very strong incentive to do it, in fact, correctly.

You only have two alternatives. Although you may have problems at the State level, please don't allow HCFA to determine the boundaries within States for alliances.

Chairman STARK. No, I share that—when you start drawing boundaries, I don't care—I mean, my theory is, the broader, the better. I mean once you begin to exclude, it is like pulling a thread on a double-knit suit. You pull very hard and in 30 seconds you are naked. And I would just assume keep it at—

Mr. SCHEPPACH. Mr. Chairman, we would get very close to a single-payer system at a very large alliance. We wouldn't want to do that, would we?

Chairman STARK. It may surprise you to know that I am somewhat indifferent to that. But while you raise the question on the issue of mandates, and as you heard us discuss earlier, if we are going to have—I happen to think that we need both universal access and universal coverage, so I don't like one without the other. Medicaid is a perfect example of universal coverage, but not necessarily universal access.

Will many States, in your opinion, be able to vote in the next couple of years to pass whatever kind of mandate is necessary—be it individual, be it on the employers, single-payer, those States, those few States that may even come up with a single-payer plan very quickly; and my sense is that that would be a terribly contentious, tough fight in a lot of State legislatures. It is a tough back here. Did you all dismiss it, put it aside because you couldn't come to an agreement? Could you comment on that?

Mr. SCHEPPACH. Well, it requires within our organization a two-thirds vote in order to support something. So you can see, given the differences of opinion. But there is some track record in States that have done this.

Hawaii has had a mandate for a long time. The State of Washington passed a mandate. The State of Massachusetts at one time passed a mandate. The State of Oregon did. You are right.

I think one of the problems is, can you maintain the long-run commitment to that? You are right, it never got implemented in Massachusetts. We had some problems in Oregon. We were concerned about the financing in Washington, although that particular referendum didn't pass. So I think that it has been happening.

Second, when you look at the Clinton plan, though, I think it is that the Federal Government is enacting the mandate. The States' question is, when do they trigger on to the system within that 2½ year window? Given the financial incentives up front and given the sanctions at the back end, I suspect that a lot of States—I mean that all States will enact within that 2½ year period.

You know, they would have been further along in this issue if we had had some ERISA waivers and some Medicaid flexibility. I mean, Governors feel very committed to moving ahead in this area.

Chairman STARK. Do you need Medicaid flexibility, or just the dollars? I mean, when I criticized the way the States have administered Medicaid, as I said earlier, had they had an open-ended entitlement, my criticism would be well founded and well deserved. But when you don't have the money, I am not sure that—

Mr. SCHEPPACH. I can't remember the exact numbers for Arizona, but as I remember, their rate of change was in the 8 to 10 percent range over the last 2 years, Medicaid for all States in 1991, and 1992 was 30 percent per year. And I would say a lot of problems in flexibility to use managed care, a lot of Governors feel very strongly that they can save a lot of money in the acute care portion of Medicaid if they had the flexibility to run their program correctly.

Chairman STARK. What would it do in Mississippi? Seventy-five bucks a month and you don't qualify. I mean, California did Medicaid some years back and had the biggest scandals of fraud—

Mr. SCHEPPACH. Well, I think there were some problems when that industry was underdeveloped. But let's face it, 40 percent of the rest of us are in some form of managed care now, compared to only 8 to 10 percent of the Medicaid population. In some form of managed care, I believe, if you include PPOs, IPAs and staff model—

Chairman STARK. Well, possibly in California, but you know, 3 percent in South Carolina,—

Mr. SCHEPPACH. The recent numbers are very high and moving very rapidly.

Chairman STARK. I agree that they are moving rapidly, and by the end of the decade, we are going to have a lot more people. But as we said earlier, there is precious little indication that that really saves any money.

Mr. SCHEPPACH. That is because they have been shadow pricing. But once they realize that they are in some serious direct competition, I think you will see huge savings.

Chairman STARK. That is a matter of faith. I would be willing to watch and see, and on that topic, there has been some indication that the Governors are not unanimous as to whether or not they choose to take over Medicare.

How do they split on that, would you say?

Mr. SCHEPPACH. Well, Medicare is particularly a problem in rural areas in terms of alliances, because rural areas have a high

percentage of elderly, and therefore, they would stay out of the alliance. Therefore, it is a problem of can you get a large enough group to get a serious alliance to provide accountable health plans in those areas? So the Governors are pretty united that they ought to have flexibility, both in the single-payer model to have Medicare in, and to get Medicare in, under some waiver provision into the alliances.

You have to remember what is going to happen is that people who are now 60 or 64 are going to be in the alliance, and they are going to reach a point at which they want to stay in the alliance if they are getting good care when they reach 65. So as this population turns over, essentially you are going to have a lot more people who are going to be in alliances and are going to want to stay in alliances. And at some point, when you reach a threshold, it may be that you want to require the rest of that population to come in as the accountable health plans become efficient and sophisticated at delivering high quality care.

Chairman STARK. But you think the Governors would not object if we said, let's wait and see?

Mr. SCHEPPACH. Well, I think the bill now has some provision in terms of a waiver to allow that. I don't think Governors are saying right now you need to mandate it in. But if there is a political consensus within a State, the Governor would have to have before he came to HCFA to ask for a waiver, that seems to make a certain amount of sense.

Chairman STARK. Yes. I would submit to you that in the plan, it is a formula to dismantle Medicare in about 5 years. And there is no reasonable way, if we took the plan as it is, they offer substantially more generous benefits to anybody turning 65. They also have a thing in there that if you are working after 65, you must stay in the plan. So you can't get into Medicare if you continue to work after you are 65.

I could go on and on, but the net result is that we would end up with this committee having only the elderly and the sickest, who would tend to want to stay with their fee-for-service physician because they have much more flexibility. We would have to capitate the payment for the new members in Medicare who generally are the least—the lowest users. And it is the 65-to-70s who pay for the 85-to-90s, and you can pretty much design—we would then be on notice to unwind Medicare in a big hurry, and we would go broke.

We have to deal with it. We have to decide whether we are going to put it in or not, and that is why the question—I am unsure. I have heard that some Governors would like it, feel it is essential if they are going to run a single-payer system; and others would say, let's wait and see. And I am of the latter camp. I didn't know if you have a strong position.

Mr. SCHEPPACH. I think where the Governors are is some process where, if they meet certain criteria, that the Secretary would in fact consider a waiver on that.

Chairman STARK. Well, let me try one other.

Would the Governors—do you know, and I don't know that this has ever been approached. One of the plans that I have suggested—I am concerned about the failure. If I must go—and I said this earlier—and promise my constituents that we will have guar-



anteed access and quality; and for whatever reason, the California State legislature gridlocks, and then how do we, how do we fulfill our promise?

I am uncomfortable with the idea of giving my political opponent the chance to say, well, see, the Federal Government plan is now imposing taxes where the State may not have been willing to, and yet the State would get the money to spend; and I can't find that accountability and responsibility. So that I am concerned that the punishment on the State may look attractive, that we may end up running some States.

I am much more comfortable where you have already suggested that we set in place and define the benefit; and insurance reform, that is something set aside. What would be the States' objection to our saying one of two things. If the State fails, people would then be, let's say in whatever the Federal plan will be—a combination, I would presume Medicaid, Medicare, and we offer that plan as the fallback. So that if, for whatever reason—can't, won't—it goes broke, there is underlying all of this a Federal safety net plan which basically would, I presume, look a lot like Medicare, and that becomes a fallback for Medicaid.

If the States choose not to take it, we subsume it into a two-tier part, into some kind of a Federal plan, and that is what happens. The State chooses not to, and we offer it as an option.

If you have a rural area and you have a couple of alliances in the State and one area is unattractive, we have an inner city area, and then they could purchase—the alliance could purchase Medicare at our cost. Is that something that you think would be—

Mr. SCHEPPACH. Well, I think, Mr. Chairman, if you are talking about doing it alliance by alliance or program by program within the State, I think that would in fact be a problem, and I think it is one of the problems we have now—

Chairman STARK. —as an option?

Mr. SCHEPPACH. I understand. Let me finish. I think one of the problems we have now is mixed accountability. If I remember the plan correctly, if the States do not in fact act, the Federal Government has the right to come into an individual State and set up alliances in the system.

Chairman STARK. And operate them?

Mr. SCHEPPACH. And operate it until such a time as the State wants to ask for it to come back.

And so I—although that is discomfiting, I think this needs to be done on a whole State-by-State basis. So it seems to me, you have the fallback for a total State if in fact the State does not—

Chairman STARK. OK. And what I am saying is the alternative fallback, let's start there, is rather than have us come into your State and operate it and assess the taxes, we just say, OK, that State is in—those people are uninsured, are in Medicare, let's just say, until the State decides to take them back.

Mr. SCHEPPACH. I am not sure we have a specific policy, but I would assume the Governors would oppose that.

Chairman STARK. You do?

Mr. SCHEPPACH. Yes. I just think dividing the State on a program-by-program—

Chairman STARK. The way it is sliced now, you have a mandate which we are not necessarily obligated to fill.

Mr. SCHEPPACH. The mandate being the financial concern or the mandate being the employer mandate?

Chairman STARK. You may be in a squeeze. In other words, the mandate is that if a date fails and we can't come up with the money, you are on the hook.

Mr. SCHEPPACH. Well, I have already indicated in the statement that we are concerned about that, and our hope is that we can in fact resolve that issue. I mean, that comes in two places.

Chairman STARK. I guess that is what I am offering you, is the alternative of saying, if it fails, there is underlying a Federal insurance program—

Mr. SCHEPPACH. Well, again, I think if that is done, it has to be done broadly for the State, not within a specific program within the State.

Chairman STARK. Absolutely. Absolutely. And optional. I am getting away from these mandates on anything, if the State chooses to use that, which could be the—if they choose to do nothing, they might—North Dakota might just say, hey, for all this, for a couple of hundred thousand people, why don't we just let insurance companies keep going, and if there are people who don't have insurance, we will let them be in this new program which is a combination Medicaid/Medicare, and we don't—that is it.

Mr. SCHEPPACH. You wouldn't consider that a foot in the door to a single-payer, would you?

Chairman STARK. Absolutely, I would. Sure. But I am not so sure that it would—if you look at the large corporations and the insurance companies and—plus the fact that the benefits are very low, so there is indeed a need for the supplemental part, which would be what Medicaid does for the poor people.

No, there is no question that that too—although in the low-cost States, Medicare would lose. If I had to bid in some States, I think a private insurer could beat us. Not in the high-cost States, not in Manhattan and not in Los Angeles; we would win.

Mr. SCHEPPACH. Would you put that under the global budget?

Chairman STARK. Yes.

Mr. SCHEPPACH. Under a federally driven global budget?

Chairman STARK. Whatever the global—whatever the budget factor is, certainly. It would be—if you are going to have a budget, it seems to me you have got to have a budget.

Mr. SCHEPPACH. I would go back to the Governors and get some guidance on that option and come back to you.

Chairman STARK. Thank you.

Mr. Thomas.

Mr. THOMAS. You indicated you had some concern about HCFA drawing the lines for alliances. Would you have some concern if they were the ones who determined the risk adjustment mechanism?

Mr. SCHEPPACH. Yes. Again, I don't—

Mr. THOMAS. The Health Board is going to determine the risk adjustment mechanism. Do you have any confidence that they are going to put together something that works? You indicated that you didn't.

The problem, as the chairman said, and he is absolutely correct, and on this we have 100 percent agreement; we have talked to everybody we know, and asked for anyone—and we solicit your support as well—is there anybody out there that can produce a risk adjustment mechanism?

It makes perfect sense, as you indicated, the larger the group, the less the sensitivity. Nevertheless, there isn't even sufficient documentation at the State level, let alone a sub-State level, to produce what is, as one expert told us, like gravity in terms of the fundamental essential nature of the plan, in adjusting for risk between alliances.

Now, I didn't see in your testimony a concern about the National Health Board and its role in creating a risk adjustment mechanism. Do you have any concern about that?

Mr. SCHEPPACH. We would like to see the Health Board or another body provide information on risk adjustments, but the State would, in fact, have flexibility to adjust within broad ranges or use, in fact, even alternatives.

Mr. THOMAS. You know that is not—excuse me. Go ahead.

Mr. SCHEPPACH. I understand that that may not be in the bill.

Mr. THOMAS. It is not in the bill.

Mr. SCHEPPACH. But I am saying that is where the Governors are on that issue.

Mr. THOMAS. OK. Once again, you describe them as though alliances are here, and you are talking about how you would like to have the alliances work. I will go back to the chairman's question. I fail to see the essential nature of a mandated alliance even in the President's own program.

Do you have any indication, has there been any discussion from the Governors along the lines of saying, let's change Federal law in terms of granting broader waivers in ERISA, and in Medicaid? Let's do antitrust changes so that professionals can talk to each other? Let's do administrative simplification to save money? Let's do a malpractice umbrella so States can move forward in that area? Let's continue the flow of funds and possibly even increase them in terms of the Medicaid so that States in their own creativeness can either move them into managed care or structure alliances if they so choose, integrated into whatever structure that the States set up?

Has there been any discussion among the Governors about that kind of an agenda?

Mr. SCHEPPACH. Most of those components are included in NGA policy, and in fact the Governors do support those components. The question is on the alliance. They do support the creation of State alliances; where they begin to differ is on who is required to purchase through the alliance. We really don't have policy on that.

Mr. THOMAS. Are we back into a universal access versus universal coverage? Because what we have in the President's plan is a mandated alliance structure approved by the Federal Government. You just said that the Governors are in favor of, in essence, the opportunity to set up alliances. I don't know anybody who is opposed to that. That isn't what the President's plan advocates.

Mr. SCHEPPACH. I think the Governors are comfortable with a mandate that they set up alliances. But when you get above that

question about who is in fact required to purchase from the alliance, then we do not have policy on that, and I think there is a difference of opinion. As I said, it goes back a little bit to the Medicaid question.

Mr. THOMAS. OK. You indicated you had some concern about HCFA regarding the lines. The National Health Board is going to draw the lines because it approves whatever the State does, and if a State is not doing something or creating a structure that the National Health Board feels is appropriate, they have full power to go in and change it. They are the same folk who are going to set up the risk adjustment mechanism.

One last question on alliances. Have the Governors or others who have been trying to game the President's plan to see if they could even possibly make it work if in fact it passed, have they contemplated the fact that according to my knowledge of the President's plan, there is no requirement that alliances be contiguous in their structure—that is, you can have four alliances in a State, and that they don't have to be a complete contiguous entity—so that it is not akin to redistricting in which you have to have a complete district?

However contorted it may be in dividing up areas, there is nothing in the President's plan that I am aware of that doesn't say that you can't locate one of the alliances in the northwest corner, in the northeast corner, in the southwest corner, in the Southeast corner, and then move another one in a different structure.

So that you might be able to construct alliances that meet the concerns in terms of the difficulty with urban areas, the difficulty with the sparsely populated areas, by creating alliances that are not contiguous?

Mr. SCHEPPACH. I have always assumed that they would be contiguous.

Mr. THOMAS. Why did you make that assumption?

Mr. SCHEPPACH. Because that is rational.

Mr. THOMAS. That is precisely the fundamental problem with the President's plan. It isn't rational. Thank you very much.

Chairman STARK. Mr. Scheppach, thank you very much for your testimony. As I say, there are some areas here where I am sure that the Governors have some differences, and where we see some problems in putting this together; and your continued assistance on helping us negotiate this will be very useful.

Thank you very much. We appreciate your participation.

Mr. SCHEPPACH. Thank you very much.

Chairman STARK. Our third witness is Leslie Aronovitz, the Associate Director, Health Financing and Policy Issues, Human Resources Division, U.S. General Accounting Office, accompanied by Bill Scanlon, the Associate Director of the Human Resources Division, and John Hansen, the Assistant Director of the Human Resources Division.

We welcome you back to the committee, and as soon as you are comfortably arranged, why, Ms. Aronovitz, you may proceed in any manner you are comfortable.

Ms. ARONOVITZ. Excuse me. I am sorry. I didn't hear you. Good morning.

Chairman STARK. Good morning.

**STATEMENT OF LESLIE ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY WILLIAM SCANLON, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, AND JOHN HANSEN, HUMAN RESOURCES DIVISION**

Ms. ARONOVITZ. Mr. Chairman, first I would like to introduce my colleagues that are sitting with me. On my left is Larry Cluff, on my near right is Bill Scanlon, and on my far right is John Hansen.

Chairman STARK. Gentlemen, welcome.

Ms. ARONOVITZ. We are very pleased to be here today to summarize our work on States' regulation of health insurance, conducted at your request. My testimony today will focus on the portion of the health insurance market currently being regulated by State insurance departments, the budget and staff resources State insurance commitment to regulating health insurance, the key activities insurance departments perform and I will also conclude with some observations on how health care reform proposals might affect the activities of States and their insurance departments.

I should note that we do not endorse the merits of any proposal, and that our observations are based on a limited review of the proposals and do not reflect a comprehensive assessment of each plan's provisions.

State insurance department oversight has generally been limited to a portion of the private insurance market. Only about 24 percent of all national health expenditures are paid through health insurers that are currently regulated by State insurance departments. These departments are responsible for regulating many different types of insurance, including health, life, auto, homeowners and other property and casualty, so therefore, their resources are spread over a wide range of insurance products.

Our study found that, on average, State insurance departments devoted about a quarter of their 1991 resources to regulating health insurance. Though this varied widely, ranging from 4 percent to 57 percent in different States, State insurance regulators—

Chairman STARK. What do you mean by resources? Do you mean people?

Ms. ARONOVITZ. The number of full-time equivalent staff.

Chairman STARK. Can you quantify that from the most to the least in numbers? Have you got that handy?

Mr. HANSEN. Mr. Chairman, the report on the results of our study will provide a table that lists them in that order.

Chairman STARK. Give me roughly, as you recall. Are there a hundred in the biggest department? 10? 1,000? I am just trying to get an idea.

Mr. HANSEN. There are a little over 1,000 in the largest department, and that would be Texas.

Chairman STARK. And of that, all of 1,000 are working on insurance?

Mr. HANSEN. No, that would be the entire insurance department staff.

Ms. ARONOVITZ. In Texas, what percent is spent on health regulation?

Mr. HANSEN. About 10 percent of the full-time equivalent staff.

Chairman STARK. So the biggest in the country is 100, and you get down to—I suppose, into the single digits pretty quickly?

Ms. ARONOVITZ. Yes.

Chairman STARK. OK.

Ms. ARONOVITZ. States face a particular challenge in protecting consumers from insurer failures, excessive premiums, unfair policy provisions and unscrupulous insurance business practices. States try to protect consumers through a number of activities, and depending on the particular State's regulatory philosophy and the level of resources devoted to regulation, we found that departments perform these activities in a variety of ways.

The principal goal and the key activity of State insurance departments is to protect consumers by monitoring the solvency of insurance companies and quickly resolving the problems of financially troubled insurers. Effectively monitoring insured financial insolvency is a very complex and difficult task and sometimes States can only work toward minimizing the effects of an insolvency on policyholders.

In addition to solvency monitoring, most State insurance departments attempt to protect consumers from excessive rates by reviewing rate insurance premiums. In regard to rate reviews, States face a challenge in balancing the consumer's interest in affordable insurance with the company's need to collect sufficient premiums to pay all future claims. There is little consensus among insurance regulators about how best to do this.

Insurance regulators also review health insurance policies because they are sometimes complex and difficult for customers to understand. States use a variety of approaches to ensure that policies comply with State laws, which often include provisions such as readability, required coverage, prohibited exclusions and a number of administrative requirements.

Finally, insurance—consumers are vulnerable to unscrupulous practices by insurance companies, such as high-pressure sales practices, improperly denied claims, unfair discrimination and improper denial of coverage. States we visited routinely used consumer complaints to help identify problem insurers and to target those companies. To protect against these unfair practices, insurance departments investigate consumers' complaints regarding health insurers. In addition, they perform what are called market conduct examinations.

In reviewing the administration's and several other health care reform proposals, we identified how these proposals may impact the States and their insurance departments. We found that the proposals provide few details on how various provisions would actually be carried out. The proposals we reviewed prescribe some role for States in establishing standards for health insurance plans' solvency, but it is unclear from the proposals what types of solvency standards States would use or how they might differ from existing State-by-State standards that are currently applicable to a variety of insurers.

The proposals also provide for health plans' revenue to be risk adjusted, but the proposals do not indicate how risk adjustment requirements would be developed to any great extent or managed.

Chairman STARK. Now, they didn't require that the State insurance commissioners do that, did they?

Ms. ARONOVITZ. No, they don't. But the States would have to carry out the risk adjustment criteria or requirement.

Chairman STARK. I wouldn't worry about that, because that shouldn't trouble them for the next 15 or 20 years.

Ms. ARONOVITZ. To further protect policyholders and providers in the event of a health plan failure, the administration's proposal also requires States to ensure that a guaranty fund exist. However, it is unclear whether this would be a new fund or an extension of the existing life health guaranty funds that exist in most States.

If risk adjustment provisions are not implemented, the administration's proposal does have a fallback and provides a role for States in establishing reinsurance programs. A different proposal assigns responsibility for monitoring the reinsurance market for health plans to a national commission. Again, these proposals don't really address how or if the States or how they would monitor the reinsurance market.

The proposals we reviewed all required the use of community rating in determining the premium rates for plan enrollees. The proposals primarily assign the responsibility for implementing these provisions to the health alliances or purchasing cooperatives, rather than the States. The reform proposals would require health insurance plans to offer a standard medical benefits package with no medical underwriting.

While the States currently review policy forms in some manner, the administration proposal is unclear about whether the States would continue to review policy forms for compliance, and other proposals don't address the monitoring role.

Finally, most proposals we reviewed would remove the handling of consumer complaints from State insurance departments to the health alliances or purchasing cooperatives. One proposal may require States to share in this responsibility. The administration proposal also assigns responsibility for monitoring advertising to the health alliances while other proposals are silent.

What we would like to say today is that although there is still much uncertainty about the final outcome of the final health care reform debate, it may involve fundamental changes in the health insurance industry and the way States regulate health insurance. States will continue to play an important role. However, this role will change as different responsibilities are imposed on States. Any reform proposal should clearly specify what States are expected to do to carry out their new responsibilities, and these expectations need to consider the wide variation in State insurance departments' existing legal authorities, regulatory activities and resources, and what actions need to be taken to ensure that States have the necessary tools to enforce new requirements on health insurers.

Mr. Chairman, this concludes my prepared statement. We would be happy to answer questions.

[The prepared statement follows:]

TESTIMONY OF LESLIE G. ARONOVITZ  
ASSOCIATE DIRECTOR, HEALTH FINANCING ISSUES  
HUMAN RESOURCES DIVISION  
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to summarize our work on states' regulation of health insurance, conducted at your request. We are also looking at how states regulatory role may be affected by the various health care reform proposals currently being discussed in the Congress.

In response to concerns about the implications of health care reform on the enforcement roles and responsibilities of state insurance departments, we conducted a questionnaire survey of the insurance departments of all 50 states and the District of Columbia. We also visited insurance departments in seven states--California, Colorado, Illinois, New York, Texas, Vermont, and Virginia<sup>1</sup>--and met with representatives of the National Association of Insurance Commissioners and the insurance industry.

My testimony today will focus on (1) the portion of the health insurance market currently regulated by state insurance departments, (2) the budget and staff resources state insurance departments commit to regulating health insurance, and (3) the key activities insurance departments perform. I will also discuss our observations on how several health care reform proposals might affect the activities of states and their insurance departments.

INSURANCE DEPARTMENTS' ROLE IN  
REGULATING HEALTH INSURANCE IS LIMITED

State insurance departments' oversight has generally been limited to a portion of the private insurance market. Only about 24 percent of the United States' national health expenditures is paid for through health insurers that are currently regulated by state insurance departments. Another 34 percent of health care dollars is paid out-of-pocket by individuals or through self-insured employer health plans that are regulated by the Department of Labor under the Employee Retirement Income Security Act of 1974. The remaining 42 percent of health care expenditures is funded and regulated by the federal government through programs such as Medicare and jointly by federal and state agencies for programs such as Medicaid.

RESOURCES COMMITTED TO HEALTH  
INSURANCE REGULATION VARY WIDELY

State insurance departments are responsible for regulating many different types of insurance, including health, life, auto, and homeowners and other property and casualty insurance. Thus, the departments' resources are spread over a wide range of insurance products. Our study found that, on average, state insurance departments devoted about 24 percent of their 1991 resources to regulating health insurance. However, estimates of individual states' resource commitments to health insurance regulation varied widely, ranging from 4 to 57 percent of insurance department budgets.

Of the states responding to our survey, 28 estimated that the number of full-time-equivalent staff involved in regulating health insurance ranged from 1 to 153, with a median of 18 staff members.<sup>2</sup> Nine of these 28 states estimated that they had less than 10 full

<sup>1</sup>We selected these states because they included both large and small insurance departments in different geographic regions and included states that had undertaken state health insurance reform.

<sup>2</sup>It is difficult for states to estimate the number of staff that oversee a particular type of insurance because state insurance departments are typically organized by regulatory activity--not line of business.



time staff involved in regulating health insurance,<sup>3</sup> and 22 state insurance departments said they were not able to estimate the number of full-time staff involved in regulating health insurance.

Some states we visited had recently enacted reforms to improve the availability and affordability of health insurance to small groups. Insurance department officials said these reforms assigned them new responsibilities that placed an increasing strain on their resources. Typically, these reforms have imposed new restrictions that limit how health insurers set premium rates and medically screen applicants.<sup>4</sup> Implementing these new reforms has increased state insurance department workloads in several areas, including preparing new regulations and ensuring compliance with new policy and rate provisions.

#### STATES PERFORM SEVERAL KEY REGULATORY ACTIVITIES

State insurance regulators face particular challenges in protecting consumers from insurer failures, excessive premiums, unfair policy provisions, and unscrupulous insurer business practices. Any one of these problems could be financially devastating to policyholders. States try to protect consumers through a number of activities. Depending on the particular state's regulatory philosophy and the level of resources devoted to health insurance regulation, we found that departments perform these activities in a variety of ways.

#### Monitoring Insurer Financial Solvency

The principal goal of all state insurance departments is to protect consumers by monitoring the solvency of insurance companies and quickly resolving the problems of financially troubled insurers. To monitor insurer solvency, state insurance departments typically perform annual reviews of insurers' financial data and conduct on-site financial exams of insurers about every 3 to 5 years.

Effectively monitoring insurer financial solvency is a complex and difficult task, in part because insurance regulators must often rely on financial information submitted by the insurer and CPA audit reports of insurer financial statements. A company experiencing financial trouble could hide its true condition from regulators by submitting misleading or false financial information. Such was the case in New York in which, according to a recent report, Empire Blue Cross and Blue Shield--the nation's largest nonprofit insurer--submitted inaccurate financial data to state regulators for years and used the data to justify the need for state insurance reforms. Although the New York State insurance department ranks second in expenditures and third in staffing among all state insurance departments, it did not identify Empire's inaccurate filings.

#### Reviewing Health Insurance Premium Rates

In addition to solvency monitoring, most state insurance departments attempt to protect consumers from excessive rates by reviewing health insurance premiums. We found that states' approaches to regulating health insurance premium rates differ. Some states require detailed rate submissions, which the insurance department reviews prior to approving or disapproving the requested rates. Others states do not routinely receive health insurance

<sup>3</sup>The nine states were Delaware, Idaho, Louisiana, New Hampshire, New Mexico, Rhode Island, South Dakota, Vermont, and Wyoming.

<sup>4</sup>Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-20, May 14, 1992).

rate information from insurers or do not have authority to regulate insurance premiums.

States face a particular challenge in balancing consumer interest in affordable insurance with insurance companies' need to collect sufficient premiums to pay future claims. There is little consensus among insurance regulators about how best to manage these competing demands.

New Jersey regulators faced this dilemma in 1992 when they had to weigh policyholders' need for affordable health insurance against Blue Cross Blue Shield of New Jersey's request for a major rate increase to stay solvent. The regulators acknowledged that they approved a smaller rate increase than the plan requested in order to ensure that the plan's premiums remained affordable. The regulators said that their decision to limit the rate increase denied the financially troubled plan an estimated \$38 million in revenue that could have bolstered its reserve position.

#### Reviewing Health Insurance Policies

Insurance regulators also review health insurance policies because they are often complex and difficult for consumers to understand. States ensure that policies comply with state laws, which often include provisions such as readability, required coverages, prohibited exclusions and a number of administrative requirements. States do this in several ways. For example, Texas uses a detailed checklist and reads each policy form line-by-line before it can be used. In contrast, insurance regulators in Colorado only require that the insurer certify that the form complies with all state laws and regulations.

#### Investigating Consumer Complaints and Insurer Market Practices

Finally, insurance consumers are vulnerable to unscrupulous practices by insurance companies, such as high-pressure sales practices, improperly denied claims, unfair discrimination, and improper denial of coverage. States we visited routinely used consumer complaints to help identify problem insurers. To protect against these unfair practices, insurance departments investigate consumers' complaints regarding health insurers. In addition, most states perform market conduct exams to review the marketing, underwriting, rating, and claims payment practices of health insurers.

In 1991, health insurance complaints comprised about 37 percent of the approximately 344,000 consumer complaints received by 45 insurance departments. The other five states did not distinguish health insurance complaints from other insurance complaints in their tracking system. Our survey found that 38 states believe that the number of health insurance complaints has increased in recent years.

#### HOW HEALTH CARE REFORM WILL AFFECT STATES IS UNCLEAR

Most health care reform proposals look to states to play an active role in implementing and enforcing new requirements on private health insurers. This role may require states to perform new regulatory tasks and regulate new organizations.

We reviewed the administration's and several other health care reform proposals to identify how they may impact the states and their insurance departments. We found that the proposals provide few details on how various provisions will actually be carried out. Moreover, the manner in which state insurance department responsibilities and activities may change under health reform is extremely uncertain and still being debated--even among state regulators. Finally, the administration's proposal authorizes

planning and start-up grants to help states implement any new activities, while another proposal would provide grants to states to establish purchasing cooperatives.

The proposals we reviewed prescribe some role for states in establishing standards for health insurance plan solvency. But it is unclear from the proposals what types of solvency standards states would use, or how they might differ from the existing state by state standards that apply to various types of insurers and health maintenance organizations. These proposals also provide for a health plan's revenue to be adjusted for the expected utilization of health services by the plan's enrollees, but they do not indicate how risk adjustment requirements would be monitored. To further protect policyholders and providers in the event of a health plan failure, the administration's proposal also requires states to ensure that a guaranty fund exists. However, it is unclear whether this would be a new fund or an extension of the life/health guaranty funds that currently exist in most states.

If risk adjustment provisions are not implemented, the administration's proposal provides a role for states in establishing reinsurance programs. Another proposal assigns the responsibility for monitoring the reinsurance market for health plans to a national commission. Again, these proposals do not address if or how states would monitor reinsurance programs.

The proposals we reviewed all require the use of community rating in determining the premium rates for plan enrollees. The proposals primarily assign the responsibility for implementing these provisions to health alliances or purchasing cooperatives, rather than the states.

The reform proposals would require health insurance plans to offer a standard medical benefits package with no medical underwriting. While all states currently review policy forms in some manner, the administration proposal is unclear about whether the states would continue to review policy forms for compliance with these requirements, and other proposals do not address the monitoring role. The administration proposal asks states to ensure that plans are actually providing the benefits promised, while other proposals do not address this issue.

Finally, most proposals we reviewed would move the handling of consumer complaints from state insurance departments to the health alliances or purchasing cooperatives. One proposal may require the states to share the responsibility with the health purchasing cooperatives. The administration proposal also assigns responsibility for monitoring advertising to the health alliances, while the other proposals are silent in this area.

#### CONCLUSIONS

Although there is still much uncertainty about the final outcome of the health care reform debate, it may involve fundamental changes in the health insurance industry. States will continue to play an important role in protecting health insurance consumers. However, this role could be more complex as new responsibilities are imposed on states. A reform plan should clearly specify what states are expected to do to carry out their new responsibilities. These expectations need to consider the wide variation in state insurance departments' existing legal authorities, regulatory activities and resources, and what actions need to be taken to ensure that the states have the necessary tools to enforce new requirements on health insurers.

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Mr. Chairman, this concludes my prepared statement. We would be happy to answer any questions you may have.

Chairman STARK. Thank you. I think I heard the gentleman who—Mr. Scheppach suggested that the Governors wanted the Federal Government to set the standards or write the specifications for health insurance regulation. Let's assume we did that. Would that make it any easier for the States? I was looking at his testimony while you were talking, he didn't really say he wanted us to regulate them and supervise them, he just set out the standards. And I presume, as he was silent on who should actually run the operation, that he thought that perhaps the State regulators should.

Is it your assessment that with the resources currently employed by the States, they would need in the aggregate substantially more resources to regulate coverage, the insurance coverage for every American?

Ms. ARONOVITZ. It is actually very hard to say, because there are going to be a whole different set of requirements. In some cases, States will take on a much more complex approach in terms of assuring solvency. They will have to certify health plans in the administration's proposal and in many of the others. To do that will involve a much more complex set of criteria or requirements, because the information on premium rates and the risk adjuster and whatever will end up complicating the matter.

On the other hand, States will not have to do certain activities that are currently being performed by them, and that would be answering consumer complaints, for instance, or reviewing policy forms in the detail that some do.

Chairman STARK. Well, on that subject, I just thought I heard you say—and maybe I read this into your testimony—that one of the ways that a State insurance commission structure is made aware of a problem is through consumer complaints.

Ms. ARONOVITZ. Right.

Chairman STARK. And if that is separated, if that goes to the alliance or the alliance doesn't happen to be basically a State office next door to the insurance regulator, you are putting the State regulators at some disadvantage, because they are not getting the 911 calls from our people who have a complaint about unscrupulous operators. Did I—

Ms. ARONOVITZ. Yes, that is exactly correct. A plan that experiences—or a plan that might be experiencing financial—

Chairman STARK. Do you mind if I eat while you talk?

Ms. ARONOVITZ. No, I don't mind at all. A plan that would be experiencing financial difficulty might be tempted to cut corners or possibly not deliver the services that were promised. In those cases, they could elicit consumer complaints.

Consumer complaints are very important as an early warning signal of possible plan difficulty. So if you are assigning the health alliance the responsibility to monitor and investigate consumer complaints, what we think you would need to do is make sure that there would be very close communication and coordination between the State and the alliances. Because if they don't get that information, then they are not going to have all the information they need to assure at an early time, early warning signals that some plans might be in trouble.

So you are exactly right.

Chairman STARK. Let me try this. And I hadn't thought about it. I was about to say, wouldn't it be simpler if we have a uniform Federal benefits package, and I guess everybody is agreed on that, to then regulate or surveil the compliance with that through a Federal structure? The answer to that would be yes, wouldn't it? No?

Ms. ARONOVITZ. I am not sure. If there is a standard benefits package, one of the real critical issues then becomes not what the plan specifies it will provide, but in fact what services the plan actually provides.

Chairman STARK. That is what I was about to get to.

Ms. ARONOVITZ. Exactly. And that still has to be monitored.

Chairman STARK. If everybody just had one simple plan and there weren't extras, because a lot of the complaints could be, well, the salesman or the plan person promised me that my kids would have braces, and that ain't in the Federal benefit plan; and so that complaint might be with—completely outside of whatever control we had.

Ms. ARONOVITZ. Right.

Chairman STARK. So it is a complicating factor.

You are silent in your report as to how we best ought to do this. Wouldn't it make sense to you if in fact the alliance must approve—OK. The State certifies the—

Ms. ARONOVITZ. The plan.

Chairman STARK. —the plan. And they certify the plan, and in that certification, obviously they must provide the benefits that we proscribe.

Ms. ARONOVITZ. Right. It is very interesting; that is, States actually have quite an awesome responsibility here in certifying plans, because not only do they have to assure—to look to see that plans look viable and that they are in financially sound condition, but also that they have the ability to provide the benefits that they say they are going to provide.

So in the process of certifying a plan and in assuring solvency or looking for solvency, the States then take on a lot of other peripheral responsibilities in terms of understanding how plans are getting their revenue through risk-adjusted premiums and what ultimately happens to plans through consumer complaints.

Chairman STARK. I guess that is all insurance regulators do is deal with integrity of the assets, adequacy of reserves.

Ms. ARONOVITZ. Right.

Chairman STARK. And that that is pretty universal across the country; is it not?

Ms. ARONOVITZ. Yes. The AIC has helped States a lot in trying to develop standards. But there is no universal agreement on what standards should be in place or what standards should be used that are the most effective.

Chairman STARK. Is there any record of any insurance commissioner taking over any insurance company or plan before it went bankrupt and saving it from disaster? Yes? Mr. Cluff, are you going to give me some examples?

Mr. CLUFF. Yes, sir, that does happen, and I can probably identify a few cases of that for you. In many cases, the State regulators do not share that information with us, because the company is now functioning again and they don't want anybody to know that it was

in trouble and then got out of trouble. One example is Monarch Life Insurance, which was taken over by the Massachusetts Department because of problems in the holding company.

The insurer is back on the street with a different structure of holding company. The department, once it identified the problem, was able to restructure the company. There are other examples as well. The failures are more public than the successes.

Chairman STARK. Are they more prevalent or just more public?

Mr. CLUFF. I can't answer that, because the States are reluctant to share that information with us on a quantitative basis.

Chairman STARK. I have always been under the impression they haven't done a very good job, based on the public results, which are the failures. But if you were to tell me that there were 10 times as many interventions that resulted in a healthy company where the benefits were all paid as agreed, one might have to conclude that the State regulators were doing a hell of a good job.

Mr. CLUFF. Well, it is difficult to say, and certainly State insurance departments do intervene at many levels; and their job is to intervene at early levels in ways that would result in the company not becoming insolvent, not being taken over, in fact. And we have been assured by the NAIC and by States that they do intervene in companies at that stage. I do not have any quantitative information about how often or how effectively that takes place.

Chairman STARK. My guess is that less often than not, or they would have been back here testifying to their numerous successes in an attempt to offset their numerous and resounding failures—California leading the way in denying benefits to crippled children and other goof-ups by our own State insurance commission. So we certainly have a sorry record there.

I want to thank you again for all of this. This is, I am sure, often boring toiling in the vineyards, but it is important for us to have your information; and I know we will be calling on you more.

By balanced budget, we are trying to cut your budget to the contrary notwithstanding. We find GAO to be a reliable and useful source of information for us, and the public is well served, and we appreciate your continued conscientious work. Thanks very much.

Ms. ARONOVITZ. Thank you. We appreciate the support of this subcommittee very much.

Chairman STARK. Our fourth witness is Ann Torregrossa, staff attorney with the National Health Law Program, and she is accompanied by the managing attorney, Stan Dorn.

Ms. Torregrossa, welcome to the committee, and if you would like to enlighten us or expand on your testimony in any way you are comfortable, why, go right ahead. And will you, too, excuse me from munching on my sandwich?

**STATEMENT OF ANN TORREGROSSA, STAFF ATTORNEY,  
NATIONAL HEALTH LAW PROGRAM, INC., ACCOMPANIED BY  
STAN DORN, MANAGING ATTORNEY**

Ms. TORREGROSSA. As you have heard, I am with National Health Law Program.

Chairman STARK. Could I also admonish you, you practically have to swallow this thing for the reporter and me and our guests to hear.

Ms. TORREGROSSA. Thank you. The National Health Law Program is a legal services national backup center which specializes in health law for low-income people. We would like to thank you for the opportunity to appear before the committee.

The President's bill has as its goal universal health care, and we think that is a laudable goal. But we are very concerned about the substantial discretion that is being given to the States under the President's plan. We base this on the State's operation of the Medicaid programs for the last quarter-century. We also base this on the fact that we work with the hundreds of legal service programs across the country who see access problems, quality of care problems of their clients day in and day out under the Medicaid programs which are administered by the States.

Now, obviously, the States' administration of Medicaid is not all bad or all good and some flexibility is needed. An example of that, of course, is the single-payer flexibility, which seems quite important. But the State has been providing health care for a quarter-century for approximately 11 percent of our country's population. We think that that is a track record that needs to be looked at before we give such substantial discretion to them under the President's bill.

As you know, the States have operated Medicaid subject to a number of Federal requirements. But there has been enough discretion given the States so that we have, in effect, 50 different Medicaid programs; and that has been part of the problem.

Now, my written testimony has given a number of examples of problems that we have seen, but I would like to focus really on two; that is, the problem of States in really regulating influential, powerful interests. An example of that, we think, is one in the Akron Beacon Journal investigative report, which we would be happy to provide to the committee, which documented the fact that in 71 cases, operators paid themselves and their relatives salaries under the Medicaid programs' nursing home reimbursement in the six-figure range. One ingenious family which owned three nursing homes used 1.2 million of the \$6.9 million that they received from the Ohio Medicaid program to pay for salaries for their family members. In fact, the owner's wife was called the best-paid office worker in Ohio for making \$338,000 in 1990 as an administrative assistant.

This is not an isolated incident. The Charlotte Observer found that similar situations were happening in North Carolina. And one nursing home operator was being paid under Medicaid to the tune of \$380,000. He also owned the pharmacy that provided the drugs, the medical supply company that provided the medical supplies, and—

Chairman STARK. Were these States paid on a cost-reimbursement plan?

Ms. TORREGROSSA. Yes, they were.

Chairman STARK. OK. Thank you.

Ms. TORREGROSSA. But we think it demonstrates that States have been unable to appropriately regulate strong politically influential entities. We also think that it shows that there have been 51 different methods of reimbursement in some cases, and it has been very difficult for the Congress to get a handle on this, to go

in and to try to correct it; whereas under Medicare, where there is one methodology, you have been able to make mid-course corrections, if you will.

Chairman STARK. Well, more or less there, the Blue Cross plan president makes \$15 million a year, but it is legal.

Ms. TORREGROSSA. That is true, and I think it is legal in Ohio and North Carolina also, unfortunately.

We think the other area that is particularly informative on this level is what the States have done as far as assuring quality health care under Medicaid. We have seen instance after instance of abusive marketing techniques in Florida and in California of our clients being lied to, of being told that they would have a box of Pampers if they signed this line to get more information about a managed care program, and in fact finding out that instead, they had just signed up for an HMO.

A woman in Florida answered the door and was told that the person in front of her was a caseworker and that if she didn't sign up for the HMO, she would lose her AFDC and food stamps.

There have been terrible instances of market abuse that the GAO has documented and remarked about.

In addition, there has been terrible instances of profiteering. The one that I am most familiar with is in Philadelphia. The HealthPass program made \$33 million in 33 months—a \$3,000 return on their \$200,000 investment, not too shabby. The problem, of course, was that during that same time women who were pregnant were not receiving as much prenatal care, nor were their birth outcomes as well as fee-for-service. So that is obviously a concern.

Finally, if you look at the May GAO study, you can see that quality assurance in the States of Medicaid-regulated programs has been of continuing concern. The GAO said, "There have been problems with quality of service and high disenrollment suggesting beneficiary dissatisfaction."

Now, if the States' administration of the Medicaid program reflects how they might administer health reform under the President's plan, then I think we all need to be terribly alarmed.

You can expect entrepreneurs trying to make huge profits. You can expect State regulators who don't have enough staff and don't have enough expertise and may not be able to stand up to these highly influential health care providers, and you may expect the quality-of-care problems that we have seen under Medicaid.

We urge you, in considering this important issue, to make sure that we have a uniform program, to make sure that there are strong Federal standards. This is important not only to protect consumers and taxpayers, but it is also important so that if something needs to be fixed as we go down this road, that we don't have 50 different fixes we can fix at one time.

Thank you.

[The prepared statement follows:]



Testimony of  
ANN TORREGROSSA  
STAFF ATTORNEY  
NATIONAL HEALTH LAW PROGRAM

Good morning, Chairman Stark and members of the Subcommittee. I am Ann Torregrossa, a staff attorney with the National Health Law Program, the legal services national back-up center that specializes in health law for low-income people. We work with hundreds of legal services programs around the country, assisting them with cases involving health care for their low-income clients. I thank the Subcommittee for the opportunity to testify before you this morning. Chairman Stark, you and other members of the Subcommittee have already done our clients a great service by repeatedly insisting that a reformed health care system must meet the needs of all, not just the well-heeled.

As a country, we need affordable, cost effective, universal health care that provides comprehensive benefits to all. The President's bill is an important effort intended to reach these goals. However, as the Congress evaluates and develops the bill in an effort to reshape our health delivery system for the future, it is critical to avoid the mistakes of the past.

The President's proposal gives great discretion to the States in operating and overseeing the health alliances and plans that are to provide health care. It is natural for states to want maximum flexibility and minimum accountability. However, the question before the Congress is whether great discretion in the hands of state government translates into good health care for consumers.

The bill is filled with many examples of such discretion, and I will mention only one. Unlike the September 7 draft plan, which assigned the National Health Board the responsibility to develop minimum quality standards for health plans, the Administration's bill leaves these standards entirely in the hands of the states. The quality of health care will depend on the states' ability to provide strong, vigorous and well-enforced consumer protections, even if this contradicts the financial interests of health plans and their member providers.

During the past quarter century, the states have played a major role administering diverse Medicaid programs. I would respectfully suggest that the states' track record shows that it is neither warranted nor wise to grant them substantial, unbridled discretion in determining vital questions of health policy.

Before giving several examples of common failures in state Medicaid programs, I must make several disclaimers. First, the states' record, of course, is not completely black or white. Some state initiatives have achieved important successes, such as case-management programs for pregnant women, or innovative home and community based care for elders or disabled people who otherwise would have been institutionalized. And second, within the general framework of the Administration's proposal, some room for variation among the states is essential. The single payer option, for example, must be preserved. But we worry that the enormous scope of state discretion in the Administration's bill will endanger the public's health and fisc, if the states' experiences under Medicaid are any guide.

### **A. The Performance of the States in Administering their Medicaid Programs.**

The states, through the various state Medicaid programs, provide health care coverage for approximately 11% of the people in our country today and oversee the administration of 15% of U.S. health care dollars. (This compares to the Medicare Program, which provides health care to 13% of our population.)

Congress has not given the states unbridled discretion in the operation of this important health initiative. Under Title XIX of the Social Security Act, states are required to operate their programs "in the best interests of recipients," and federal law mandates numerous requirements for adequacy of benefits and access to care. Within the ambit of such requirements, states are allowed great discretion in designing their Medicaid programs. As a result, the fifty states have very different programs.

The following examples illustrate the problems legal services advocates have observed in states' operation of Medicaid programs, problems far greater in scope than those observed under the federal government's Medicare system.

#### **1. States have failed generally to provide their Medicaid recipients with adequate access to health care providers.**

Federal law requires states to set reimbursement levels that provide Medicaid patients with "equal access (to health care providers) ... compared to the general population." States have the discretion to design provider reimbursement schemes so long as Medicaid beneficiaries obtain such equal access.

As I'm sure you know from your constituent calls, Medicaid beneficiaries have distinctly inferior access to health care, not the equal access called for by the law. Many Medicaid beneficiaries continue to rely on hospital emergency rooms for their care, because they cannot find primary care providers and specialists willing to accept Medicaid's usually inadequate reimbursement amounts. Many rural residents must travel for hours to clinics in urban areas, even though their own towns have doctors.

In the mid-1980s, in eight rural counties in California, pregnant women on Medi-Cal, California's Medicaid program, could not find an obstetrician willing to see them. In rural Massachusetts, pregnant teenagers have been forced to undergo dangerous delays in commencing care as they searched for a provider willing to accept Medicaid. Closer to home, Shirley Beer, who is disabled by coronary artery disease, and her husband, who is diabetic and blind, often must travel several hours from their home in rural Armstrong County to Pittsburgh because the doctors in their town will not see Medicaid patients. The Beers are SSI recipients in their 60's who do not have a car. Their journey to obtain health care is made more painful by the knowledge that proper administration of the Medicaid program would make the arduous trek unnecessary. Their friends and neighbors on Medicare face no comparable problem.

It should be noted that the President's plan may overcome this serious concern, because the bill assures that health plans receive equal payments, regardless of whether consumers are covered by Medicaid. Notably, this important and positive requirement does not give the states any discretion.

**2. States have lacked the regulatory capacity to take on the powerful health care industry even when their own pocket books have been at issue.**

Given great discretion in determining provider reimbursement, state Medicaid programs sometimes pay so little that beneficiaries are denied care. At other times, however, states pay too much and for the wrong things.

The Akron Beacon Journal published a remarkable investigative series on the failure of Ohio to properly oversee the powerful nursing home industry in that state. Headlines from the series tell the tale: "Medicaid Gravy Train--Some nursing home owners are putting your tax dollars to work by stuffing their families pockets....Nursing Home Salaries Dwarf Major Hospitals."

According to the article, the Gaitanaros family has 3 nursing homes in Ohio, two of which were cited for federal and state violations, including understaffing, failure to properly treat bed sores, and in adequate food service. Over half of the funding for those homes comes from Medicaid. Of the \$6.9 million the Gaitanaros family receives from Medicaid to reimburse for the cost of providing care for Medicaid residents, they use \$1.2 million to pay salaries of family members. The Beacon labeled Mrs. Gaitanaros as "the best-paid office worker in Ohio" for making \$338,964 in 1990 "for toiling 40 hours per week as an office manager and administrative assistant". The Beacon found that this was not an isolated incident.

"At least 71 operators paid themselves or their relatives six-figure salaries in 1990 according to a computer analysis of Medicaid cost records" for Ohio nursing homes.

Headlines in The Charlotte Observer herald a similar problem in North Carolina: "Some Elderly Suffer in costly nursing home system...N.C. Helps Nursing Homes Enrich Owners...Regulators, Operators Party; Taxpayers Pay Part of Bill...Public Helps Pay Lobbyists" The North Carolina Medicaid Program pays for 75% of the beds in that state. The Observer found that the North Carolina Medicaid Program "reimburses (nursing home) owners based on how much they spend regardless of their profits or of how well they take care of people." One person operates 28 homes in North Carolina for which he pays himself at least \$380,000. But he also owns the development firm that builds the homes, the pharmacies that sell the homes the drugs, the medical supply company that sells the homes the syringes and catheters, and the therapy company that goes into the homes to teach residents to walk again -- all at inflated prices, billed to the taxpayers.

Articles from New York state also chronicle "soaring nursing home profits" under the Medicaid Program and editorialize against a rate increase, following an annual jump of over 100% in profits. We would be glad to provide the Subcommittee with all these articles.

These stories yield several important lessons. First, states usually lack the capacity for strong regulation and enforcement, even when their own budgets are on the line. Second, the enormous variation in reimbursement methodologies among state Medicaid programs has prevented the Congress from curbing abuses. Unlike the Medicare program, where a single reimbursement methodology permits national corrections of emerging problems, Medicaid nursing home reimbursement methodologies vary so enormously that Congress has been unable to take strong steps to curb egregious waste of taxpayer dollars. It would be a dangerous mistake to give states even more significant discretionary responsibilities in the context of general health care reform.

**3. States have often failed to provide an adequate scope of benefits under the Medicaid Program despite federal requirements to the contrary.**

Federal law requires states to provide benefits in sufficient amount, duration and scope to achieve their objective. Within this general federal requirement, states are given the discretion to design coverage rules. Virtually every state in the Union has been sued successfully under this federal provision and forced to provide Medicaid recipients with the health care their doctors deemed medically necessary.

Pennsylvania's Medicaid Program provides one example. When the Medicaid Program began in the mid 1960's, the Pennsylvania Medicaid Program adopted the Blue Shield Plan C Medical-Surgical Fee Schedule. However, the state did not update it for almost two decades, until it was forced to add over 600 procedures as a result of a class action lawsuit. Before this law suit, the state's Medicaid program refused to cover cat scans, ultra sound, and new radiation therapies and chemotherapy for cancer. Long before the suit, Medicare patients had access to these crucial, often lifesaving services.

**4. The states' administration of managed care programs under the Medicaid Program has been particularly dismal.**

States have turned to managed care for their Medicaid recipients in an effort to contain Medicaid cost increases. According to HCFA, Medicaid managed care enrollment more than doubled between 1987 and 1992, and included about 3.6 million beneficiaries nationwide as of June 30, 1992. Under most managed care systems, health plans are paid a single, capitated amount per patient, regardless of how much care they provide. When patients receive more care, the plans lose money. This incentive to underserve has generated a strong need for consumer protections in the Medicaid context, and the same will be true under health care reform if increasing numbers of us enroll in managed care plans.

On the whole, states have done a dismal job of protecting Medicaid recipients from the abuses of the managed care system. The states' failure to oversee managed care properly has been evident in many areas, three of which I will mention this morning: (1) marketing practices; (2) profiteering, at the taxpayer's expense; and (3) quality of care.

**a. States have not effectively regulated the marketing practices of managed care entities.**

The managed care industry has found the Medicaid population to be most profitable. The scheme is simple: sign them up; take the taxpayers' money; and provide little or no care. In many locations, managed care plans compete for Medicaid beneficiaries. One HMO in Miami told beneficiaries waiting in food stamp lines to sign cards if they wanted more information. Unbeknownst to the Medicaid beneficiaries, their signatures enrolled them in the HMO. They learned this only when their regular pharmacy could not fill their prescriptions, or when their regular doctors at the community clinic said they could no longer care for them.

Diane Jones of Miami was enrolled in a Medicaid managed care program when someone, claiming to work at the Department of Public Aid, solicited her at her door. This person, who actually worked for an HMO, told Ms. Jones that she would lose her food stamps and her AFDC benefits if she did not sign up. She signed up and now has greater difficulty accessing health care. In San Diego, California, Medicaid patients are routinely forced to enroll in HMOs, as HMO employees falsely state that Medicaid coverage will end if they don't sign up for the HMO. Other managed care plans offer mothers free pampers if they will sign a sheet of paper. Later, it turns out that the signature resulted in enrollment in a managed care plan.

Under the Administration's plan, the states that have permitted these abuses to flourish would be responsible for everyone's health care, not just health care for the poor.

**b. States permit taxpayer funds to increase provider profits, rather than to provide health care for Medicaid beneficiaries.**

States usually enter into provider agreements with managed care entities for a capitated rate that is less than what would be spent under fee-for-service Medicaid. Accordingly, huge managed care profits means either that (a) beneficiaries are denied necessary health care, or (b) the managed care entity was paid too much in the first place. Generally, states have not investigated to determine whether recipients received the care for which they were paid, even in the face of huge profits.

The HealthPass Program, an HMO for Medicaid patients only, made \$33 million dollars during its first 33 months of operation between 1989-1992. This caused the one federal inspector to state in a 1992 report that HealthPass "was in imminent danger of becoming a cash cow". HealthPass owners made an over 3,000% return on their invested equity of \$200,000. At the same time, poor women in HealthPass suffered worse prenatal care and birth outcomes than did women receiving fee-for-service Medicaid. Mercy Health Plan, which operates in the same area and is a nonprofit corporation serving Medicaid recipients, made a \$40 million profit

between 1988-1992. Particularly disproportionate profits were observed in the area of mental health services, where Mercy acted simply as a conduit of funds to a mental health contractor. Similarly, advocates in Arizona report that the state's lauded managed care program has allowed some providers to retain 40% of mental health funds to cover "administrative expenses."

c. States have not effectively assured that Medicaid recipients receive needed care from managed care plans.

The GAO study released in May (HRD-93-67, p.43), entitled "States Turn to Managed Care to Improve Access and Control Costs", found that "there have been problems with quality of service and high disenrollments, suggesting beneficiary dissatisfaction." The study also found that states and plans have not always complied with quality assurance systems and procedures. This is also confirmed by numerous recipient complaints received by legal service programs around the country. Here are a few examples:

\*In Miami, Florida, a young child's tooth became infected and needed to be extracted. The managed care plan informed the mother that it would extract the tooth, but without anaesthesia.

\*Over the summer, our office received a call from a 19-year-old pregnant teenager in Fresno, California. She tried repeatedly to obtain prenatal care from her managed care plan, which persistently turned her away, after making her sit in its waiting rooms for hours at a time. Finally, an unaffiliated obstetrician informed this teen that the managed care plan did not include a single maternity care provider. She then tried to disenroll from the plan so she could receive prenatal care elsewhere. Eventually, she succeeded. But we do not know whether this high-risk teen received more than one prenatal care visit, despite great efforts on her part.

\*In San Bernadino County, California, one managed care plan routinely disenrolls patients who are admitted to the County's trauma care center. While this saves money for the managed care plan, it means the patients go without care for thirty days or more as fee-for-service eligibility is re-established. Many low-income people have been denied crucial care as result, such as follow-up skin graft clinic treatment after admission for severe burns.

## **B. Overall Perspective on State Involvement and Recommendations.**

If the states' administration of their Medicaid programs reflects how they might administer universal health care under the President's proposal, we should all be extremely alarmed. One can expect greedy health care entrepreneurs, intent on realizing huge profits, flocking to bid to participate as health plans. One can anticipate state regulators without the necessary staff, the necessary expertise, or the political will to stand up to politically influential entities in the managed care industry, to require them to provide quality health care and spend money on

needed health care, rather than simply pocket the funds and deny essential services. One can predict marketing violations, inadequate scope of benefits, inadequate access to specialists and other health care services. This is the states' overall track record in administering the Medicaid Program, which contains far more federal requirements to protect consumers than are included in the Administration's bill.

These problems often result, not from venality or malice, but from insufficient public resources. Staffing is a serious issue for state governments today. Although they receive matching federal funding under the Medicaid Program for administration, many failures to administer adequately state Medicaid programs have been due to lack of staff. States must run balanced budgets and are often reluctant to increase taxes. This has resulted in drastically understaffed state governments, particularly in the areas of health and welfare. States cannot take on the extra burden of overseeing the health care for all in their state without significantly increasing their expertise in quality assurance and oversight and gaining trained staff for this purpose.

Several steps must be taken to prevent these structural problems from endangering patient care. First, health care reform should establish a mechanism to develop enforceable, minimum federal requirements for quality assurance and oversight. Overall, we urge members of the Subcommittee to include strong, national standards to govern the development of health care reform. Not only does such an approach better protect consumers and taxpayers, it permits vigorous, national course corrections that would be impossible if states were implementing very different reform systems. Second, HHS should be given the time it needs to review state proposals carefully, with an eye to protecting the consumer. It is striking that HHS is given, for example, seven working days to decide whether state health policy applications are complete. HHS then has ninety days to act on completed applications; delay beyond ninety days means automatic approval. These procedures ignore that health care policy questions are often quite difficult. That is why the Congress received a health care bill long after the passage of the Administration's original May deadline. Safeguarding of patient care means that HHS likewise must be given the time it needs to rule on state proposals for new systems of health care.

### C. Conclusion.

No more than once in a generation is there a window of opportunity to realize huge gains that profoundly improve the lives of our people. Earlier this century, our nation's leadership had the courage to enact Social Security in the 1930's. We are at a similar juncture with the possibility of universal health care in the 1990's. If we are to ask employers, workers, and the federal and state governments to pay for a new health care system, we must ensure that it is a system that provides us all with affordable, appropriate, comprehensive, and cost effective health care. To ensure this we must have a uniform program with strong federal standards. Let us not repeat the mistakes of Medicaid.

Chairman STARK. Thank you. While we haven't focused on the Medicaid program, because it is really not within the jurisdiction of this committee, the President's plan gives the States primary responsibility in a number of very critical areas; and the only model we have of States running a major medical operation is Medicaid.

Ms. TORREGROSSA. That is true.

Chairman STARK. So it becomes important for us to try and assess how well they have done.

Now, I am going to assume you are more familiar with this than I am. Is there anything inherent in the design of the President's State alliances that you can see that gives you some hope that many of the problems you illustrate would be resolved or could be dealt with better than they are?

Ms. TORREGROSSA. Well, obviously, the blended rate is terribly important from the perspective of our clients being folded into the alliances with the same payment structure. The size of the alliances and where they are, of course, is of concern.

Chairman STARK. Let's just take the State alliance, the universal State board or alliance. There might be several.

Ms. TORREGROSSA. Oh, OK.

Chairman STARK. Is there anything inherent in the structure of those alliances that you think will result in better management of plans or better protection of the consumer than the way the States are handling it now?

Ms. TORREGROSSA. Well, they are appointed by the Governor, as I understand, the members of the alliance.

Chairman STARK. Yes. They are consumers, they can't be providers.

Ms. TORREGROSSA. There are limitations on conflict of interest. There will be some consumer representation, which hopefully will be helpful, depending on whether or not that consumer is just a consumer or someone who is knowledgeable and can represent consumer interests. I would think there would be a lot of scrutiny of the actions of the alliance, and I think now much of what is done under Medicaid is behind closed doors with State officials and the health care providers. So there may be some benefit to that.

Chairman STARK. There are, aside from just the 51 different Medicaid programs that are largely an indemnity program, there are some States that have attempted to get into some kind of a more universal managed care. California has done it, 13 counties I guess, and some States have done it universally.

Can you comment on any particular State program, managed care or managed competition or anything else that stands out as being a singular success in the array of Medicaid programs?

Ms. TORREGROSSA. Mr. Dorn has been specializing in that, and I think he would be better able to answer that question.

Chairman STARK. Mr. Dorn.

Mr. DORN. Sure. Just a couple of examples. I can think—for example, in California in the early to mid-1980s, there was a case management program for pregnant women that provided not just health care, but also psychosocial assistance, transportation; and it so significantly improved birth outcomes and ultimately saved money that even Governor Deukmejian approved, and the program was significantly expanded State wide.



Chairman STARK. You are editorializing, Mr. Dorn. But that is all right. I agree with you. But was that State wide or was that in certain counties?

Mr. DORN. It was pilot in selected areas of the State and then was expanded State wide, based on that success.

Chairman STARK. Contra Costa County, represented so ably by George Miller, has a plan for their Medicaid population that is quite good; I don't know if you are familiar with that. But then a private Medicaid HMO was licensed to come in and take up to one-third. The county had the responsibility for running the Medicaid program. They let this operator come in and go door to door and solicit, basically cherry-picking, took a third of the income away from the county, but took none of the severe cases, and that soon ended in a disaster.

So I think these things have to be sort of State wide or you get a tremendous adverse selection of problems.

Mr. DORN. That point is very well taken, and I know there are a number of—there are proposals on the table in California now, I understand, to do similar things in other counties; and I think your point is very well taken about the adverse selection consequences.

Chairman STARK. The District of Columbia, are you familiar with their plan?

Mr. DORN. Not in as much detail as California's.

Chairman STARK. Any other plans that come to mind as having been a success? Go ahead.

Mr. DORN. There are some other examples of community-based, long-term care programs that been implemented in a number of States.

Chairman STARK. Let's stick with acute care for a minute.

Mr. DORN. There have been other examples of case management programs that have gotten more high risk populations into care. As Ann said, we can't say it is an all black and white situation. Just a fairly dark shade of gray.

Chairman STARK. OK. Would you say that there are sufficient guidelines under this President's plan to ensure that the plan doesn't become a complete Medicaid-for-all structure? Are you comfortable with—

Ms. TORREGROSSA. Absolutely not.

Chairman STARK. Absolutely what?

Ms. TORREGROSSA. Absolutely not. There are far fewer protections in the President's plan for consumers than there are in Medicaid and we have seen what has happened with Medicaid.

Chairman STARK. The President is trusting to your and my and our families' ability to, given the proper information and information on quality, to make reasoned choices, where we will then become enlightened consumers. And under the Jackson Hole theory, we will pick what is best for us at the most reasonable price. Shouldn't that solve the problem?

Ms. TORREGROSSA. No. The question is what do we have to pick from, who is going to make sure it is something decent that provides care, and make sure that people who need outreach in order to be brought into the health care system are reached for.

If you look, for instance, under Medicaid, we have far more outreach efforts than we do under the President's plan. The President's plan just allows States to—I think the wording is may use additional money to do outreach. But it doesn't require them.

Chairman STARK. Are you familiar with the Prudential Company's recent experience in providing advice to their investment clients?

Ms. TORREGROSSA. I am not one of Prudential's investment clients. I am not familiar with it.

Chairman STARK. It ran in the press about the hundreds of millions of dollars of bad investments they sold and are now under some sort of court record to reinstate. Are you familiar with that?

Ms. TORREGROSSA. No.

Chairman STARK. Would you be comfortable turning over the health care program to a company like Prudential?

Ms. TORREGROSSA. Absolutely not, no.

Chairman STARK. How about Equitable? They are another big company that just had some resounding successes in peddling through the televangelists' se radio networks some policies that turned out to be less than promised. Would you feel comfortable with people like that—

Ms. TORREGROSSA. Absolutely not.

Chairman STARK. —taking care of your mother's health care?

Ms. TORREGROSSA. I think we have to ask whether the States, given some of these records, whether they have the ability to provide the oversight, because you know the new entities and old entities such as this are going to be flocking in an effort to get a piece of this action.

Chairman STARK. I read in the paper, I must say, as you know, I was late for this morning's hearings, but some of these large companies who anticipate the riches that will be available to them in the plan are out buying up all the primary care practitioners. I am not sure how one buys a family practitioner or a general practitioner, but I am sure that is an area of commerce and a commodity—I wonder if you can buy futures in it, pork bellies and family practitioners. Interesting sort of speculation. And I wonder if doctors will become interest rate sensitive in the market.

Well, thank you very much. The Chair obviously shares your concern that there is a lot of room for mischief in a \$900 billion enterprise. It doesn't take much shading for the dice to fall to the disadvantage of the consumers on a majority of the rolls.

I appreciate the good work that your group does. I hope you will continue to alert us of those areas of which we should be somewhat more vigilant. Thank you very much for your testimony.

We will recess for about 5 minutes, seventh inning stretch, and proceed then to our final panel.

[Brief Recess.]

Chairman STARK. We will resume. And our fourth panel will include Alissa Fox, executive director of Blue Cross and Blue Shield Association; Linda Jenckes, senior vice president of Health Insurance Association of America, bridge partner to the First Lady; Craig Sadick, senior director of Government Relations, National Association of Wholesaler-Distributors, representing the Voluntary Purchasing Cooperative Coalition; Sam Cunningham is the presi-

dent of the Association of Health Insurance Agents, representing the National Association of Life Underwriters; Alan Katz, who is the principal of Centerstone Insurance and Financial Services, and he is the legislative chairman of the National Association of Health Underwriters; John Gummere, the chief executive officer of the Phoenix Home Life Mutual Insurance Co.

Why don't you lead off, Alissa.

**STATEMENT OF ALISSA FOX, EXECUTIVE DIRECTOR, BLUE CROSS AND BLUE SHIELD ASSOCIATION**

Ms. Fox. Thank you, Mr. Chairman.

I am Alissa Fox of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield plans provide coverage to 67 million people. The Blue Cross and Blue Shield Association strongly supports the President's objectives for health care reform: Health care coverage for everyone, strict new standards for insurers, and cost containment through managed care.

Under the President's proposal, these reforms do not begin until States create health alliances to oversee the system. We believe hinging reform on having health alliances up and running in all 50 States will delay reform and jeopardize its success. Moreover, we don't believe mandatory health alliances, large or small, are needed to achieve the objectives of universal coverage and cost containment.

We believe that almost all the functions of the alliances are or could be accomplished through implementation of new standards for health plans or could be carried out by existing State agencies.

First, the Administration says that the health alliances are needed to pool purchasing power. It is important to understand that under the Administration's proposal, the health alliance is not what gives groups better rates. Instead it is the new Federal requirement that health plans must community rate their business, that is, the health plan must offer their best rate to everyone in the market, because they must sell coverage to everyone at the same exact price.

The community rating requirement is what gives everyone the best price, and you don't need an alliance to do it.

Proponents of health alliances argue that alliances are needed to reduce administrative costs. No question about it, administrative costs need to be reduced. We believe this is best accomplished by standardizing benefits, reducing marketing costs, eliminating paperwork for consumers, and standardizing forms for providers.

Large, mandatory alliances, as proposed by the President, would increase administrative costs by duplicating functions now performed by health plans and employers that won't stop doing many of the same functions. Some believe alliances are needed to administer risk adjustment to even out the risk pools of the health plans. However, risk adjustment when it is developed, and we agree with you there, Mr. Chairman, we don't have one that exists today, could be easily accomplished outside an alliance.

Some also think you need an alliance to monitor health plan compliance and collect and disseminate consumer information. We believe the State insurance departments could do both. In fact, even with an alliance, State insurance commissioners would be re-

sponsible for certifying health plans and enforcing solvency and other standards.

Finally, we don't believe alliances are needed to offer individuals an expanded choice of health plans. Large employers today often offer several different types of options for their employees. Small employers could offer similar options or could participate in a voluntary alliance to allow their employees to choose from a menu of health plans.

Besides the fact that alliances aren't needed to accomplish the objectives, people underestimate the magnitude of the responsibility and what will be duplicated by these new entities. Managing the enrollment and premium collection of millions of individuals within a one to 2 month annual open enrollment period is truly an enormous undertaking that is fraught with complexity and the very real potential of failure.

Mr. Chairman, while we believe there are ways to improve upon the President's plan, I want to make it absolutely clear that the Blue Cross and Blue Shield Association supports health care reform and we want to work with you over the next year to make health care reform a reality. Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF ALISSA FOX  
BLUE CROSS AND BLUE SHIELD ASSOCIATION**

Mr. Chairman, and members of the Committee, I am Alissa Fox, Executive Director of Congressional Relations of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million people.

The focus of my testimony today is the provision for large, mandatory health alliances in the Administration's recently announced health care reform proposal. My comments are based on what our organization has learned in the six decades since we brought the concept of community-based prepayment for health care to the American people.

**Goals of Health Care Reform**

The Blue Cross and Blue Shield Plans are committed to the same goals of cost containment and universal coverage that shaped the President's health reform plan. We believe that these goals can be achieved, however, without relying on mandatory health alliances of any size. We believe that voluntary alliances may provide administrative efficiencies for small employers and may facilitate individual choice.

**Insurance reform.** We believe that strict federal standards for the market conduct of insurers is the first and most important step toward reshaping the health care market -- and assuring fairness to consumers. New standards for health insurers both would assure the availability of insurance and bring about real price competition for the first time in the financing and delivery of health care. Federal standards defining a health plan should:

1. Require insurers to accept everyone regardless of their health status or employment;
2. Strictly limit the length and use of waiting periods for pre-existing conditions and prohibit them entirely for people who have been continuously covered;
3. Prohibit insurers from dropping people or groups when someone gets sick, and require insurers to offer continued coverage when a person loses his or her job;
4. Require insurers to set premiums fairly for the young and the old, the sick and the well; and,
5. Require insurers to comply with requirements for administrative simplification, including increased reliance on electronic data interchange and conformity to standards.

These same strict standards must apply to more than insurers and Health Maintenance Organizations. Self-funded plans must play by the same rules and be held to the same standards as health plans.

**Cost Containment.** Federal standards also are needed to allow individuals, employers and employees to weigh both price and quality when purchasing coverage. These federal standards should:

1. Standardize health benefit designs. A limited number of standardized benefit designs will allow consumers to easily compare products, although we do not

believe a single standardized benefit design will be workable. These benefit packages should be the same in all states, and should be the same for large and small employers, as well as individuals and families who do not purchase coverage through an employer.

2. Provide consumers with standardized data on quality of care and subscriber satisfaction. Standardized measures of quality and subscriber satisfaction will enable consumers to select a health plan based on both cost and quality. To hold administrative costs to a minimum and enable more meaningful comparisons, the federal government should develop standard measures that can be adopted by the states.
3. Limit to an amount consistent with cost-efficient health plans the federal tax deductibility for employers, and the tax exemption for employees, of employer contributions for health benefits. Changes in the tax treatment of employer contributions for health benefits will strengthen the incentives for employers, employees and individuals to weigh price more carefully when selecting a health plan. As price becomes more important to consumers, health plans will make greater efforts to find more effective ways of managing costs.

These federal rules would encourage the expansion of organized delivery systems that have a proven ability to change inefficient and ineffective utilization patterns and cause providers to become more efficient providers of health care.

**Universal Coverage.** Insurance reform would reduce the number of people without insurance benefits, but it would not lead to universal coverage. A requirement for employers to offer and contribute to the cost of health benefits, and for individuals to accept and pay for the balance of the premium, would be necessary to achieve universal coverage.

Because such a requirement would impose a severe burden on many small employers, subsidies would be needed. These subsidies should be targeted to companies that rely heavily on low-wage workers and must be defined by the federal government.

#### **Mandatory Health Alliances Are Not Necessary**

Under the Clinton proposal, all individuals and families in firms with less than 5,000 employees would enroll in a health plan through a regional alliance. Individuals would enroll in the regional alliance in the area in which they reside. There would be one alliance per geographic area, and the alliance would contract with all state-certified health plans. Each individual would enroll in a health plan through the alliance as an individual; employers would have no role in selecting coverage or overseeing the health plans used by their employees.

We do not believe that mandatory health alliances -- large or small -- are necessary to achieve the goals of cost containment or universal coverage. All but one of the functions envisioned for the health alliances are, or could be, accomplished through strict federal standards for insurance reform combined with stronger incentives for employers and individuals to purchase cost-effective health plans -- without adding a new administrative layer.

- States, not alliances, would assure that all individuals and small employers have access to coverage by requiring all health plans to: accept all applicants regardless of their medical or employment status; not drop an individual or a

group because of medical problems; and set premiums in a way that does not penalize older or sicker workers.

- States would require health plans to set rates for large community-rated pools so that individuals and small groups have the same ability to pool high-risk and low-risk individuals as large employers. Even under an alliance structure the "pooling" takes place at the health plan not in the alliance.
- Requirements for administrative simplification would reduce administrative costs by standardizing benefits, reducing market costs, eliminating paperwork for consumers, and standardizing forms for providers. Large, mandatory alliances would increase administrative costs by: 1) moving several thousand employer transactions to millions of individual transactions, and 2) duplicating functions of health plans that must continue.
- An alliance is not needed to negotiate with health plans on behalf of individuals and small groups. If health plans were required to charge the same rates for all individual and small group enrollment, all health plans would have an incentive to drive the best bargain for everyone. Limiting the amount of tax-free coverage that employers and consumers can purchase to the cost of an efficient plan, and giving employers and consumers the information they need to select a health plan based on price, performance and service levels would cause health plans to compete vigorously on price.
- State insurance commissioners could collect and disseminate to consumers information on price, quality and consumer satisfaction. Insurance reform could require health plans to provide such information.
- Even with an alliance, state insurance commissioners would be responsible for enforcement of federal standards for market conduct, quality and solvency.
- Risk adjustment to account for some health plans enrolling a disproportionate share of older or sicker individuals could be accomplished just as easily outside an alliance through an independent agency operating under the supervision of the state insurance commissioner.
- An alliance is not needed to offer individuals an expanded choice of health plans. The choices available to individuals can be expanded in a number of ways without creating a large, mandatory alliance. Large employers today often offer several different types of health plan options for the employee and could be required to do so. Small employers could offer similar options or could participate in a voluntary alliance to allow their employees to choose from a "menu" of health plans.
- An alliance would be necessary to administer indirect subsidies. Such indirect subsidies would result from:
  - allowing states to purchase coverage for Medicaid recipients at 95 percent of what the state is currently paying for Medicaid benefits. Many states currently pay providers at rates that are below prices established in the more competitive private market. If state payment rates are, for example, even 75 percent of those prevailing in the private sector, then the cost of providing the guaranteed benefits for Medicaid recipients could exceed the state's premium payment by more than 40 percent.

- Individuals or employers who fail to pay premiums would continue to receive coverage (health plans are prohibited from dropping individuals for nonpayment), and their bad debts would be spread across all other employers and individuals through an assessment on premiums.
- Premium payments by employers for part-time workers may fall short of the employer's share of the premium, requiring full-time workers to pay more for coverage.

However, we believe these costs should be subsidized directly rather than "hiding" them in a complex alliance structure.

### **Problems With Establishing Mandatory Health Alliances**

We believe that a number of problems would result from establishing large, mandatory health alliances. As a result, a strategy that depends on health alliances -- as defined by the Administration's proposal -- being up and running before any reforms become effective has a high risk of failure. Mandatory health alliances are unnecessary and only would delay much needed reform.

The health alliances would be called on to perform an extraordinary range of functions:

- enrolling all eligible working and nonworking individuals;
- collecting premium contributions by employers, employees and individuals, many of whom will have no connection to the workforce or an employer;
- making payments to health plans;
- making available to all consumers comparative information on health plans;
- approving all marketing materials used by health plans;
- regulating health plans; and
- administering indirect subsidies.

It is very risky for reform to depend on establishing new entities to carry out this extraordinary range of functions.

Turning these private sector functions over to a government agency is not necessary and would result in a huge bureaucracy. The health alliances would not be as efficient as the private sector in performing key functions. For example, efficient collection of millions of dollars in premiums is critical; every day of cash flow lost would increase borrowing costs and premiums. They also would not be as responsive as a private sector entity to inquiries from individuals or employers. Furthermore, health alliances would increase administrative costs by duplicating many functions now performed by health plans.

### **Alternative Strategy to Mandatory Health Alliances**

We believe that the objectives of health care reform can be achieved through many of the proposed reforms without relying on large, mandatory health alliances.

Requiring health plans to compete on the basis of price and quality would drive down costs as consumers choose a basic benefits package. Reform in the insurance



market that requires health plans to compete on the basis of cost is the best strategy for cost containment.

First, coverage could be guaranteed without a health alliance. Guaranteed issue, guaranteed renewal and strict limits on the use of pre-existing condition exclusions would enable all individuals and small employers to obtain coverage regardless of health status.

Second, risks could be pooled without a health alliance. A community rating requirement would allow small employers to spread their risks over a large population and realize the same advantages as large employers.

Third, price competition would occur without a health alliance because employers, employees and individuals would choose a health plan, for the first time, on the basis of its price and quality of service. Standardization of benefit packages would allow individuals to more easily compare health plans and community rating would allow individuals to compare price. Tax policies would encourage individuals to select the most cost-effective plan that meets their needs.

Fourth, administrative costs for small employers could be reduced without a health alliance. The standardization of health benefit packages would reduce administrative costs. Insurance reform would eliminate the medical underwriting expenses incurred by insurers that try to avoid poor risks.

Finally, individual choice of health plans could be achieved through several strategies. Employers could be required to offer multiple health plans. Multiple choice of plans could be facilitated through administrative simplification requirements, electronic data interchange and funds transfer, or the development of new capabilities by payroll processors and other vendors of services to small businesses. Voluntary health alliances also could be formed to allow small employers to offer their employees a choice of health plans on an individual basis.

Chairman STARK. Linda, we have you next.

**STATEMENT OF LINDA JENCKES, SENIOR VICE PRESIDENT,  
HEALTH INSURANCE ASSOCIATION OF AMERICA**

Ms. JENCKES. Good afternoon, Mr. Chairman. As always, it is a pleasure to be before you because it is important, as you well know, to have an open discussion and dialog on the various questions and needed answers on the President's proposal as well as any other health care reform proposal that is before the Congress so that we can pass health care reform that is not only within our financial capabilities but is also doable and within public expectations.

I would like to begin by noting that the HIAA commends the President and the First Lady for focusing on the need for universal coverage with the American public. As you well know, 37 million Americans are without coverage, and many with coverage fear that they will lose it.

The time is right for a reform proposal that brings security, savings, quality, choice, simplification, and responsibility. We agree with these cornerstones of the President's bill. We sincerely hope the Congress can meet the challenge laid down by the President and have legislation enacted into law next year.

Within the context of those principles, we support very specific objectives which when taken together would significantly improve our health care financing and delivery system and give all Americans health coverage from start to finish. While the HIAA strongly supports comprehensive reform built on universal coverage, we do have serious doubts about several of the features in the Administration's plan. In the broadest sense, the President's plan erects an enormously complicated bureaucratic structure which could undermine and not foster an improved system. The HIAA believes it is appropriate for the government to establish guidelines and rules governing a reform system. However, we do not believe that the government should in fact run the system.

As you heard this morning, health insurance is regulated today either by State law or in the case of self-insured plans, by the Employment Retirement Income Security Act of 1974, commonly known as ERISA. State insurance regulation has been and is an effective mechanism for protecting consumers' interests.

State insurance departments in conjunction with the National Association of Insurance Commissioners have been leaders and innovators in health insurance reform. In fact, 29 States have passed small group insurance reforms in their entirety, and most of the others have passed various elements and will be considering the remaining ones in the coming year. In spite of the achievements, among others, the parameters of system reform to achieve universal coverage must be established at the national level. Only the Federal Government can ensure universal coverage for all Americans. State-by-State reform, even at a comprehensive level, has a number of significant drawbacks.

In terms of alliances, the member companies of HIAA do not oppose health insurance purchasing alliances. What we oppose is making health insurance purchasing alliances the only entity through which over 200 million Americans can buy their health insurance coverage. Let me cite some reasons.

First, monopoly alliances are not necessary to bring the health insurance purchasing power of big business to small employers and individuals. Every individual can be given the same insurance buying power as a large corporation if fundamental market reforms are enacted and enforced as a matter of law.

Second, as we have heard this this morning, a risk adjustment mechanism, some way of matching premium revenues received by health insurers, with the underlying risk of the population they are enrolling is necessary, whether an alliance is mandatory or voluntary. As you know, we will have more to say on this subject when we testify before you next week.

Third, the administrative savings potential claimed to be associated with purchasing alliances clearly has not been demonstrated, even in the HIPC or the purchasing cooperatives set up in the State of California. These functions performed by the HIPC in California are limited to enrollment, premium, billing, collection, and some marketing. No claims payment, case management, utilization review, research and development, finance, computer support, or accounting functions are included in that figure.

One final observation is that the Administration's regional alliances are not simple purchasing cooperatives providing individuals and small groups with buying leverage in the market. They are organizations with huge budgets, considerable authority, and a broad range of responsibilities. As Laura D'Andrea Tyson indicated, I believe to you yesterday, Mr. Chairman, the alliances will require 50,000 employees to operate them.

In closing, I would just like to say that insurance reforms such as guaranteed issue and renewability, rating and underwriting restrictions, and preexisting condition limitations are indeed the reforms that will lead to the elimination of risk based marketing by insurance carriers. We believe in such a reformed environment. Voluntary purchasing programs will provide the opportunity to test the various theories surrounding what value added services such programs can bring to the health care system.

The HIAA stands ready to assist you and the committee, Mr. Chairman, so that we can move forward on totally comprehensive reform for everyone. Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF LINDA JENCKES  
HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning Mr. Chairman and members of the Subcommittee. I am Linda Jenckes, Senior Vice President of the Health Insurance Association of America, headquartered in Washington, D.C. HIAA represents 270 commercial insurance companies who cover approximately 65 million Americans. The HIAA appreciates this opportunity to present its views on health insurance purchasing alliances and the role of the states under the Administration's legislation.

On September 22 and again on October 27, the President directed the nation's attention to one of the most important issues to be considered by this Committee and this Congress: comprehensive health care reform. The President is to be commended for using the power of his office to focus on the need for universal coverage. Thirty-seven million Americans are without coverage and many with coverage fear they will lose it. The time is right for a reform proposal that brings security, savings, quality, choice, simplification and responsibility. **We agree with these cornerstones of the President's bill.**

Within the context of those principles we support very specific objectives when, taken together, would significantly improve our health care financing and delivery system. Those objectives are:

- "Cradle to grave" coverage for all Americans.
- No exclusions for existing or previous illness.

- Coverage cannot be canceled if you get sick.
- If you change jobs or lose your job, coverage goes with you.
- Employers and employees both pay toward coverage.
- Subsidies for those who cannot afford premiums.
- Control malpractice lawsuits and unnecessary tests.
- Publish price and quality data.
- Single claim form to control paperwork.
- Incentives for healthy lifestyles. Emphasis on wellness and prevention.
- Stop shifting costs of Medicaid and Medicare to those with private insurance.
- Using managed care to control costs.

While the HIAA strongly supports comprehensive reform built on universal coverage, we have serious doubts about many of the features of the Administration's plan. In the broadest sense, the President's plan erects an enormously complicated bureaucratic structure which could undermine, not foster an improved system. The HIAA believes it is appropriate for the government to establish guidelines and rules governing a reformed system. We do not believe, however, that government should, in fact, run the system.

Health insurance is regulated today either by state law or in the case of self-insured plans, by the Employee Retirement Income Security Act of 1974. State insurance regulation has been, and is, an effective mechanism for protecting consumers' interests. State regulation of insurance has

worked because of the departments' close proximity to the consumers they are charged to protect.

State insurance departments, in conjunction with the National Association of Insurance Commissioners (NAIC), have been leaders and innovators in health insurance reform. The NAIC developed model acts and regulations on the subject and a significant number of states, often with the insurance departments taking the lead, have enacted comprehensive small employer insurance reforms.

However, the parameters of a system reformed to achieve universal coverage must be established at the national level. Only the federal government can ensure universal coverage for all Americans.

State-by-state reform, even at a comprehensive level, has a number of significant drawbacks. The most destructive of these is economic competition among states that would be created by the imposition of state-based employer mandates and taxes to assure universal coverage.

Under the President's legislative proposal submitted to the Congress on October 27, the bureaucratic burden that would be imposed on top of states current responsibilities would increase dramatically.

According to bill language, each state must become a "participating state" by January 1, 1998. To do so, they must submit and obtain approval by the National Health Board of a "system document" describing the State health care system to be established pursuant to guidelines established by the bill.

The bill provides for the Federal Government to operate, through the Department of Health and Human Services (HHS), of a State health care system if a state fails to establish its plan by January 1, 1998 (Title I, subtitle F, Part 2, subpart B). If the system is operated by HHS, the Secretary of the Treasury is allowed to place a 15% surcharge on health plan premiums to cover their costs -- which is counted in determining compliance with regional alliance budget targets. Doesn't this unfairly tax employers for the inaction of a state government?

There are significant additional responsibilities assigned to the states. A state would be required to establish one or more regional alliances, certify health plans, assure the financial solvency of health plans, and designate an agency or official charged with coordinating the State responsibilities under Federal law.

The member companies of HIAA do not oppose health insurance purchasing alliances. What we oppose is making health insurance purchasing alliances the only entity through which over 200 million Americans can buy their health insurance coverage. We believe the creation of such monopoly alliances would reduce competition and, in turn, reduce the quality of services provided to the health care consumer.

The reasons most often cited by supporters of monopoly purchasing alliances are (1) that monopoly alliances are necessary to bring purchasing power to small business and individuals, (2) that monopoly alliances are necessary to prevent risk selection and (3) that monopoly alliances will reduce administrative costs. The HIAA does not believe that the first two reasons are valid and believes that the third should be tested before a monopolistic alliance structure is imposed on the nation.

First, monopoly alliances are not necessary to bring the health insurance purchasing power of big business to small employers and individuals. Every individual can be given the same insurance buying power as a large corporation if fundamental market reforms are enacted and enforced as a matter of Federal law. Those fundamental and comprehensive reforms are wholeheartedly supported by the HIAA.



As a matter of Federal law, it should be illegal for an insurer to turn anyone away. In other words, every insurer should be required to take all comers, or "guarantee issue" its products. Pre-existing condition clauses should be banned as a matter of Federal law, once universal coverage is achieved. Health insurance should be guaranteed renewable as a matter of Federal law so that coverage cannot be canceled just when someone needs it most. As a matter of Federal law, health insurance rates should not be allowed to vary depending on the health status of the insured. Instead, rate variations should be permissible only if they are based on objective demographic data such as age and geographic region.

If those fundamental reforms are accomplished, any individual should be able to get the same rate for the same coverage whether he or she is part of a large group or is by himself or herself. Many small businesses and individuals have joined together to purchase their health insurance through a health plan offered through an association of which they are a member. The Clinton health plan eliminates association plans.

Second, a risk adjustment mechanism (i.e., some way of matching premium revenues received by health insurers with the underlying risk of the population they are enrolling) is necessary whether an alliance is mandatory or voluntary.

The American Academy of Actuaries' has said that "under most reform proposals, some form of health risk adjustment will be required to allow reform strategies to work effectively." We agree. This is because all reform proposals, including HIAA's own Vision for Reform, call for open enrollment and rating restrictions of one degree or another and thereby disassociate the premium the carrier is allowed to charge from the costs the carrier expects to incur in serving a particular individual or group.

If we want insurers to compete on their ability to manage the cost of providing needed care, rather than on their ability to select the healthiest risks -- and we do -- then we have to make sure that the premiums insurers charge reflect only their administrative efficiency and their effectiveness in managing care; not variations in the underlying risk of the people they have enrolled.

This is what a risk adjustment mechanism is supposed to do. Whether a successful risk adjustment mechanism can be developed remains to be seen. Various methods have been proposed, but none has yet been tested for this purpose on an employed population. We have a group of actuaries looking at the problem, and they tell us that much depends on whether insurers are enrolling groups or individuals.

The difference in health care costs from individual to individual in a given year is extremely large. The variation among employer groups, even relatively small ones, is much less.

If individuals get to pick, as individuals, which health plan they want, their knowledge of their underlying health situation is likely to influence their choice of plan. Somebody with 2 or 3 chronic conditions, for example, is more likely to choose a conventional fee-for-service plan, to guarantee that they will be able to see all the specialists they have already established relationships with. Somebody with few health problem is more likely to choose a plan with a limited network of providers, especially if it is less expensive. This leads to a situation in which plans that offer greater choice of provider tend to get sicker enrollees than the average.

Theoretically, an effective risk adjustment mechanism would adjust for this biased selection. As a practical matter, however, our actuaries tell us that no system capable of adjusting for this kind of systematic biased selection has yet been developed and tested. Significant further research will be needed. HIAA research staff is working with member company actuaries to conduct the initial research and test models that would be applicable on an interim basis.

On the other hand, the risk characteristics of employer groups are better known and can be estimated with readily available demographic data. Until a better risk adjuster can be developed and demonstrated, our actuaries believe an interim mechanism can be implemented based on information that is currently available to carriers. The mechanism would adjust for differences in geography, family type, age, gender and industry to the extent these characteristics are reflected in their premium rates. The mechanism would also include a mandatory reinsurance pool for spreading the cost of a limited number of high-cost, nondiscretionary conditions among all carriers and insureds. A critical point is that this interim mechanism will work adequately only if insurers are enrolling employment-based groups of individuals. The mechanism is not sufficient to adjust for the biased selection that is likely to occur if individuals choose their own health plans. This is another reason why we think mandatory health alliances with individual choice of plan are not viable.

Third, the administrative savings potential claimed to be associated with purchasing alliances has not been demonstrated. While some have held up as a shining example the efficiencies of a statewide program in operation in California, the Health Insurance Plan of California or the HIPC, we think that is being oversold. The functions performed by the HIPC in California

are limited to enrollment, premium billing and collection, and some marketing. No network contracting, provider management, claims payment, case management, utilization review, research and development, finance, computer support or accounting functions are included in that figure. These and other administrative functions continue to be performed by the 18 health plans within the HIPC, so analyses using the figures of that program compared to total administrative costs of health plans today is not an apples-to-apples comparison. It is important to keep in mind that the California HIPC is a voluntary purchasing pool.

We believe the alliance concept should be debated on its own merits. That is, whether the alliance itself adds value to the consumer. The HIAA member companies do believe that a purchasing cooperative approach has the potential to put collective pressure on the outside market that might be greater than what the market is able to provide itself. For example, the California marketplace has become extremely competitive, given the entrance of the HIPC into the marketplace. The price of the alliance has given strong incentives to the outside market to keep costs low and offer more services, choice and value. In a mandatory environment, such competitive pressures would evaporate. And, we believe the competitive forces at work in a voluntary environment are what will ultimately lead to

competition based on value added services to consumers--price, quality and service--rather than on risk avoidance.

We believe the rules must be the same for all participants in the market. In such an environment, we find it difficult to envision how the alliances would be inherently disadvantaged. They would be forced to succeed or fail based on their true value added to the health care consumer. While numerous papers exist casting doubts on whether mandatory alliances will work, no arguments have been advanced to say voluntary alliances would be unable to compete in a reformed marketplace.

There may be other value added features that the alliances could provide. Our point is simply that the alliance concept should be debated on the merits of such features. The alliance should not be given market share by legislative fiat, let them compete for it.

Rather than discuss purchasing alliances in terms of theory, I'd like to discuss a real working program. There currently are seven states which have passed purchasing alliance legislation, all seven states passed voluntary alliances. Although one other state has an operational pool, only California is actively and aggressively marketing the purchasing pool as a competitive alternative in a reformed marketplace. In February of this

year, one of our member companies, Employers Health Insurance, was hired by the state of California to administer and market that program and I'd like to provide some background on that program to illustrate, based on its short experience, how things may occur in the real world.

In 1992, the California legislature passed a comprehensive small group reform bill. AB. 1672 included sweeping underwriting and rating reforms and provided guarantee issue of all products to employers with 5 to 50 employees (4-50 in 1994 and 3-50 in 1995 and thereafter). The law also limited the prohibition of pre-existing condition clauses, provided for portability of pre-existing condition clauses, and enacted guaranteed renewability of groups of all sizes. In addition, the new law created the Health Insurance Plan of California (The HIPC), the first such statewide small group purchasing alliance.

Like most such purchasing alliances under discussion Federally, the California plan was designed to aggregate the buying power of small employers, offer individual employee choice of an array of health plans, and centralize certain administrative functions in an effort to lower costs. The HIPC is a voluntary program, operating in competition with a reformed, outside market. Currently 18 carriers offer a choice of 19 health plans (16 HMOs and 3 PPOs), with benefits standardized through

regulation. A total of four benefit plans are offered through the HIPC, two PPO plans and two HMO plans, a high and low option in each with the only difference between them being cost sharing provisions. Not all plans are available in all areas, however, there is no area in the state with fewer than four choices. State law allows for some minor variation in rates due to health status outside the alliance. However, premiums within the HIPC are community rated by class, allowing for rate differentials based only on benefit plan, age, geographic location and family status. In other words, premiums cannot vary due to health.

Employers make the decision whether to participate in the HIPC program. If the employer chooses the HIPC, the individual employees choose whichever health plan offered in their area they feel best meets their individual and family needs. Employers participating in the HIPC are required to contribute a minimum of 50% of the least expensive premium for "employee-only" (single coverage) in their area, however the average employer contribution currently is 80 percent.

The pool became operational May 10, with effective coverage starting July 1, 1993 when the reform law became effective. As of November 1, 1993, more than 1200 employer groups and 20,000 individuals are covered in the program.



While few conclusions can be reached with just four months of data, some interesting trends are beginning to develop. For example, despite the fact that employers are able to purchase coverage directly from the HIPC and avoid the costs associated with agent commissions, 79 percent of the current business was sold through independent agents. This indicates to us that small employers value the services of an independent counselor when selecting employee health benefits -- so much so, they knowingly pay an additional cost for it.

Price competition is an important feature of the program and the reformed outside market, but individuals are not choosing the lowest-cost plans available to them. Instead they are gravitating toward the "lower cost" plans, that is those plans in the lower-half price range of the plans available. Prices within the HIPC are, on average, about 10 percent lower than plans offered in the outside market, due mainly to limited benefits. However, for every employer that purchases coverage through the HIPC, another five employers look at the program and choose to buy elsewhere. In a mandatory purchasing environment those employers would not have the choice of purchasing elsewhere.

Several debates about anti-selection were held prior to the law's enactment -- would the PPOs or HMOs get the better risks or would the outside market attempt to shift the less healthy, older risks to the pool? Again, it will take a year or two before we have statistical evidence regarding this issue.

We have been able to gather some demographic data to date. Fully 80 percent of the covered individuals choose one of the HMO options, split evenly between the high and low cost-sharing provisions. Twice as many of the remaining 20 percent choose the "high" PPO option as compared to the "low" PPO option. The demographic breakdown of the individuals covered mirrors a "typical" breakdown in the California marketplace, which may be further along in adapting to managed care than other states. Nearly 80 percent of the covered individuals are under the age of 50, 60 percent are under the age of 40; males slightly outnumber females; the average group size is just over nine employees, and the average family size is just under two people.

Although limited and certainly not statistically credible, the California experience so far tells us many things. In a reformed market, voluntary alliances are able to compete, provide an array of choice, cause competition to focus on service and price, and put the individual consumer in the driver's seat. We don't know exactly why, but it would appear that

alliances may not be the best answer for rural communities. So far, the vast majority of participants in the HIPC come from the most populous areas of the state, with Los Angeles drawing the most participants, San Francisco second, and San Diego third.

The health alliance structure envisioned in the Health Security Act effectively bars the entry of new plans after the initial years. Plans not selected in the first year will be unable to compete in the region, and will not be around to bid the following year. Within a few years, only a handful of competitors will remain in each alliance area. The plans that survive may not be the most efficient and effective. Success in the early years of the alliance may depend more on a plan's ability to "sell" itself to individuals consumers through media advertising, than on the quality or efficiency of the care it delivers. The plan creates a disincentive for competition that would lead to market constriction. If consumers do not like the plans offered by the alliance and are on the receiving end of poor customer service (for example, they can't get their calls to the 800 number answered) they do not have any alternative -- it is the "only game in town."

The Administration characterizes regional alliances as simple purchasing cooperatives providing individuals and small groups with buying leverage in

the market. Their alliances are not simple purchasing cooperatives. They are organizations with huge budgets, considerable authority and a broad range of responsibilities. Laura D'Andrea Tyson, Chair of the President's Council of Economic Advisors, stated recently that the alliances will require 50,000 employees to operate them. The breadth and scope of activities of these regional alliances exceeds that of most existing agencies of state government today.

Regional Alliances must carry out several functions now performed by health plans, such as assembling and disseminating health plan marketing information, enrolling individuals in health plans, issuing "health security" cards, assisting enrollees with coverage complaints, and negotiating fee schedules annually with health professional groups.

They must operate, in a sense, as welfare agencies in determining family eligibility for premium discounts and cost-sharing subsidies, and helping those families apply for appropriate discounts.

Insurance reforms such as guaranteed issue and renewability; rating and underwriting restrictions; and pre-existing condition limitations are the reforms that will lead to the elimination of risk-based marketing by insurance carriers. We support a reformed system in which risk selection

is no longer a competitive factor. Under the newly reformed system, carriers will compete on price, quality of care and high service levels, something I believe we all hope to achieve.

We believe in a such a reformed environment, voluntary purchasing programs will provide the opportunity to test the various theories surrounding what value added services such programs can bring to the health care system, without gambling the security and future of health care coverage for all Americans in the process. In a mandatory approach, where do the millions of Americans go if the system doesn't work, the infrastructure will no longer exist. And what provides the benchmark to see if this approach is better or more efficient than that which we would have under the fundamental reforms we've outlined?

Mr. Chairman, the HIAA stands ready to assist the Committee in any way it can. We support comprehensive health care reform. I'd be happy to answer any questions the Committee might have.

Chairman STARK. Mr. Sadick.

**STATEMENT OF CRAIG SADICK, SENIOR DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS, ON BEHALF OF THE VOLUNTARY PURCHASING COOPERATIVE COALITION**

Mr. SADICK. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman. I am Craig Sadick, senior director of government relations for the National Association of Wholesaler-Distributors. NAW represents wholesaler firms and their members which collectively total more than 45,000 companies. I am testifying today on behalf of the Voluntary Purchasing Cooperative Coalition and appreciate this opportunity to share our perspective on health care reform for the subcommittee as it considers the question of health alliances.

The Voluntary Purchasing Cooperative Coalition represents small and mid-sized businesses, consumers, agricultural interests, health plans, and their insurance agents. Our coalition was formed to work for dynamic, market-based health care reform, which maintains the competition and open market entry that are the strengths of our existing health care system.

Our members believe that substantial reform is needed but that structural market reforms and privately run purchasing cooperatives should be the building blocks of a new system.

The coalition supports a reformed system which guarantees a level playing field to individuals and small firms in purchasing health coverage, and eliminates any incentive for cherry picking or risk selection by insurers.

We think carriers should compete on the price and efficiency of their plans and not on their ability to find low risks.

We share the President's vision for insurance market reforms which include guaranteed enrollment, renewability and portability of coverage and the elimination of preexisting condition exclusions. However, the coalition believes that the structure of President Clinton's proposed health alliances is too regulatory, too centralized, and will quickly result in a politicized system of regional bureaucracies which will limit competition and hamper the efficiencies of a reformed market.

For example, in Los Angeles up to 20 million people could be covered through the alliance, and the alliance budget would be as big as the State of California's budget. It is unlikely that this will be a nonpolitical, quote, cooperative.

Additionally, the alliances are designed to disenfranchise employers by eliminating their ability to participate in negotiating benefits and to control costs. Under the President's mandatory single alliance system, employers will be required to pay 80 percent of the costs of health care coverage through a single government organized regional health alliance, whether or not the alliance is an efficient negotiator or purchaser.

Employers recognize the advantage to businesses and individuals of pooling purchasing power in a private cooperative. And we support a system which maximizes this leverage. But employers do not want to join a government-run pool where they are required to pay

mandated health payroll taxes to support a purchasing authority over which they have no control.

A system of multiple, voluntary purchasing cooperatives in each region will allow small firms and individual consumers to organize in large groups, to have even greater market clout than large employers in negotiating with health plans. But unlike the President's monopolistic health alliances, or the plan developed by the conservative democratic forum, this market driven model is distinguished by competition between purchasing cooperatives and health plans, which our coalition believes will foster efficiency and ensure that consumers and businesses have the power to demand high quality, cost-effective plans.

Mr. Chairman, if a wholesaler-distributor or any business has the option of joining a cooperative that will negotiate better health coverage and reduce administrative costs, they will join. But the market and not the government should dictate their decision. The government should intervene, but only to set strict rules to ensure a fair system, not to manage the system.

We believe health care reform must emphasize competition over-regulation, choice over constraints, and market forces over big government. Thank you.

Chairman STARK. Thank you, Mr. Sadick.

[The prepared statement and attachment follow:]

STATEMENT OF  
CRAIG SADICK  
NATIONAL ASSOCIATION OF WHOLESALE-DISTRIBUTORS  
ON BEHALF OF  
THE VOLUNTARY PURCHASING COOPERATIVE COALITION  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS & MEANS  
FRIDAY, NOVEMBER 5, 1993

Mr. Chairman and distinguished members of the Subcommittee, I am Craig Sadick, Senior Director of Government Relations for the National Association of Wholesaler-Distributors, composed of individual wholesale distribution firms and a federation of national commodity line associations and regional, state and local associations and their members which, collectively, total more than 45,000 companies. I am testifying today on behalf of the Voluntary Purchasing Cooperative Coalition and appreciate this opportunity to share our perspective on health care reform with the Subcommittee as it considers the question of Health Alliances.

The Voluntary Purchasing Cooperative Coalition represents small and mid-sized businesses, consumers, agricultural interests and health plans and insurance agents. Our diverse coalition was formed to work for a dynamic, market-based health care reform which maintains the competition and open market entry that are the strengths of our existing health care system. Our members believe that substantial reform is needed, but that structural market reforms and privately run purchasing cooperatives must be the building blocks of a new system.

The Coalition supports a reformed system which guarantees a level playing field to individuals and small firms in purchasing health coverage and eliminates any incentive for "cherry picking" or risk selection by insurers. We think carriers should compete on the price and efficiency of their plans, and not on their ability to find low risks. We share the President's vision for insurance market reforms, which include guaranteed enrollment, renewability and portability of coverage, and the elimination of preexisting condition exclusions.

However, the Coalition believes that the structure of President Clinton's proposed Health Alliances is too regulatory, too centralized and will quickly result in a politicized system of regional bureaucracies which will limit competition and hamper the efficiencies of a reformed market.

For example in Los Angeles almost 20 million people would be covered through the Alliance -- and the Alliance budget would be far larger than the state of California's budget. It is unlikely that this will be a non-political "cooperative." Additionally, the Alliances are designed to disenfranchise employers by eliminating their ability to participate in negotiating benefits and to control costs. Under the President's mandatory single Alliance system, employers will be required to pay 80% of the costs of health care coverage through a single, government-organized regional Health Alliance -- whether or not the Alliance is an efficient negotiator or purchaser.

Employers recognize the advantage to businesses and individuals in pooling purchasing power in a private cooperative, and we support a system which maximizes this leverage, but no one wants to join a government-run pool where they are required to pay mandated health payroll taxes to support a purchasing authority over which they have no control.

The Coalition believes that a system of voluntary health insurance purchasing cooperatives can accomplish exactly the same objectives as the quasi-governmental monopolies envisioned by the Clinton health reform plan, but with less regulation, less bureaucracy, more savings and minimum government intervention. A system of multiple, voluntary purchasing cooperatives in each region will allow small firms and individual consumers to organize in large groups to have even greater clout than large employers in negotiating with Health Plans. But unlike the President's monopolistic Health Alliances or the plan developed by the Conservative Democratic Forum, this market-driven model is distinguished by competition between purchasing cooperatives and health plans which our Coalition believes will foster efficiency and ensure that consumers and businesses have the power to demand high-quality, cost-effective plans.

Mr. Chairman, if a wholesaler-distributor, or any business has the option of joining a cooperative that will negotiate better health coverage and reduce administrative costs, they will



*Voluntary Purchasing Cooperative Coalition November 5, 1993*

join. But the market, and not the government, should dictate their decision. The government should intervene -- but only to set strict rules to ensure a fair system -- not to manage the system. Health care reform must emphasize competition over regulation, choice over constraints and market forces over big government.

Thank you.

**ADDITIONAL SUBMISSION**  
**VOLUNTARY PURCHASING COOPERATIVE COALITION**  
**SUBCOMMITTEE ON HEALTH**  
**COMMITTEE ON WAYS & MEANS**  
**NOVEMBER 5, 1993**

**THE VOLUNTARY PURCHASING COOPERATIVE COALITION**

**WHO'S IN AND WHY:**

**SMALL BUSINESSES** do not want to be forced into single Health Alliances (HAs) or Health Plan Purchasing Cooperatives (HPPCs).

- ☐ Cooperatives offer the benefit of pooling purchasing power and administrative costs. But businesses want business-run cooperatives -- not government run cooperatives.
- ☐ Small businesses do not want to be forced into one regional HA or HPPC -- where they have to buy through a monopoly cooperative. Small businesses should also have the choice of buying health insurance through agents or from purchasing cooperatives.
- ☐ The problem for small business is that costs are exploding. They want to organize themselves to gain control of costs, and get more market leverage -- not lose control of employee benefits by handing cost decisions to a politicized, quasi-governmental monopoly HPPC.
- ☐ If a small business has the option of joining a cooperative that will negotiate better health coverage and reduce administrative costs -- they will join.
- ☐ But if a mandatory, single, government-run alliance is inefficient or ineffective, where can the businesses go?
- ☐ Multiple voluntary cooperatives allow businesses to join the most effective pool. With the ability of carriers and new alliances to enter the market, competition will force cooperatives to be efficient -- or lose members.

Market reforms can resolve the "cherry picking" or risk selection problems of competing cooperatives or alliances -- but only the competition among pools will drive efficiency into the system.

**CARRIERS and PROVIDER NETWORKS** want the option to compete in a reformed market.

- ☐ All the carriers agree on the need for market reforms such as guaranteed access, renewability, portability and limitations on preexisting conditions. They also agree on the need for rate reforms and prohibitions on risk selection.
- ☐ But they do not agree that exclusive cooperatives should dominate each market.
- ☐ Consumers and employers (who pay the majority of coverage costs) want a choice of efficient plans. Competition and market reforms will force that efficiency. Carriers want to compete on a level playing field.
- ☐ Carriers and employers should have the chance -- in a reformed market -- to offer a better product outside the cooperative. Competitive pressure can help prevent inefficient and complacent HPPCs.
- ☐ Only the potential for new market entrants -- and competition -- will force purchasing cooperatives to provide the best services -- at the best cost -- to small business.

**CONSUMERS** want security in health care, portability of coverage, and the option to purchase coverage at group rates through large pools.

- ☐ They also want to avoid losing coverage or paying high rates if they become sick. But they want these reforms through the efficiency of a competitive private system.
- ☐ They do not want excessive government regulation or intervention that will inevitably add bureaucracy and raise costs.

**AGRICULTURE INTERESTS** are mostly made up of farmers who purchase insurance individually. Managed care and managed competition are irrelevant concepts in rural areas with a limited number of providers.

- ☐ These farmers and agri-businesses support the idea of privately organized business cooperatives to help them pool their resources and negotiate a better price in the health care market.
- ☐ They do not want to be forced into a single government run or sponsored monopoly co-op that will inject more government and more bureaucracy into their health care system.

**INSURANCE AGENTS** want to continue to serve as the consumer source of information on choice, price and quality in health plans. Agents believe that participation in a purchasing cooperative or "alliance" must be voluntary.

- ☐ Small businesses and consumers want the option to obtain their insurance from an agent and receive the personal service that a cooperative or alliance may not provide.
- ☐ Consumers deserve a choice of health plans. Individuals and businesses see the agents as their best source of information to evaluate coverage options.
- ☐ There is a clear need for educating and advising consumers, and polls continually show that consumers trust their agents -- and strongly prefer the advice of a private agent to that of government employees (or a catalog or 800 number) -- who would likely perform those roles in a single monopoly alliance.
- ☐ In a single alliance model, the alliance presumably will be responsible for explaining the options to consumers -- but only the options the HA offers.
- ☐ Agents believe that carriers must be able to compete -- in a reformed market -- with a private cooperative.
- ☐ In a single monopoly alliance system, the alliance will inevitably become an inefficient, government-like regulator that limits -- not enhances -- dynamic competition in the health care markets.

**IF A BUSINESS, A CONSUMER, A CARRIER AND THE AGENT CAN PRODUCE A BETTER BENEFITS PACKAGE THAN THE ALLIANCE OR COOPERATIVE -- WITHOUT "CHERRY PICKING" -- THE CONSUMER SHOULD HAVE THE ABILITY TO CHOOSE THAT OPTION. SUCH COMPETITION IS GOOD FOR THE HEALTH PURCHASING COOPERATIVE, GOOD FOR CONSUMERS AND GOOD FOR THE HEALTH CARE SYSTEM.**

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## VOLUNTARY PURCHASING COOPERATIVE COALITION

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### Membership

- |  |  |
|--|--|
| <input type="checkbox"/> Alabama Retail Association                              | <input type="checkbox"/> National Association of Life Underwriters       |
| <input type="checkbox"/> American Institute of Architects North Carolina Chapter | <input type="checkbox"/> National Association of Wholesaler-Distributors |
| <input type="checkbox"/> Associated Builders and Contractors                     | <input type="checkbox"/> National Retail Federation                      |
| <input type="checkbox"/> Bertholon Rowland                                       | <input type="checkbox"/> National Small Business United                  |
| <input type="checkbox"/> Blue Cross of California                                | <input type="checkbox"/> New York Life Insurance Company                 |
| <input type="checkbox"/> Communicating for Agriculture                           | <input type="checkbox"/> Pacific Printing & Imaging Association          |
| <input type="checkbox"/> Consumer Alert  | <input type="checkbox"/> Petroleum Marketers of Iowa                     |
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| <input type="checkbox"/> Indiana Manufacturers Association                       | <input type="checkbox"/> REA Marketing Systems, Inc.                     |
| <input type="checkbox"/> Mass Mutual   | <input type="checkbox"/> Texas Association of Insurance Agents           |
| <input type="checkbox"/> Midwest Truckers Association                            | <input type="checkbox"/> The Principal Financial Group                   |
| <input type="checkbox"/> Missouri Merchants & Manufacturers Association          | <input type="checkbox"/> The Travelers                                   |
| <input type="checkbox"/> Mutual of Omaha   | <input type="checkbox"/> Western Growers Association                     |
| <input type="checkbox"/> National Association of Health Underwriters             |  |

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November 3, 1993

Chairman STARK. Mr. Cunningham.

**STATEMENT OF SAM J. CUNNINGHAM, PRESIDENT, ASSOCIATION OF HEALTH INSURANCE AGENTS, NATIONAL ASSOCIATION OF LIFE UNDERWRITERS**

Mr. CUNNINGHAM. Mr. Chairman, my name is Sam Cunningham. Today, I am speaking on behalf of the Association of Health Insurance Agents and the National Association of Life Underwriters; 143,000 life and health insurance agents across the Nation.

I come to you today not only as a health insurance agent who works to meet the needs of thousands of clients who are also small employers and health insurance consumers, I am also a small businessman who pays taxes, meets a payroll, provides benefits, and does all the other things that an employer has to do.

I make my living by virtue of the services I provide to my clients. I am in the business of providing access to complex medical care delivery systems while advising individuals and businesses in methods of keeping costs down. If I don't perform well for my clients, if I don't provide cost-effective health plans at an affordable price, if I don't provide good service, then the client goes elsewhere. In other words, we are up for reelection every 30 days. I am proud to point out that the vast majority of my clients have been with me for many years.

Having said this, I did not come here to talk about defending the status quo. Far too many Americans don't have health insurance protection and many others don't have decent coverage. We strongly believe in universal health care for all Americans provided through an employer-employee partnership that can be funded through a variety of revenue options. For many years, agents have educated their clients about health insurance benefits and served as trouble shooters in helping their clients interact with insurance companies.

Because small employers often do not have the luxury of a human resources department, agents fill a critical role in a cost-effective manner. We help employers decide how to select health insurance plans that will meet the needs of its employees and the company's affordability and ability to finance the plan. When our agents sell a policy, companies are purchasing a lot more than a contract for medical services. They are getting an experienced, knowledgeable professional. The agent is looking out for the best interests of the client.

President Clinton's health plan mandates that employers with fewer than 5,000 employees purchase their coverage for employees through a health alliance. Under this scheme, employers would be prohibited from direct purchasing arrangements with a health plan.

Mr. Chairman, there is much in the Administration's proposal with which we can agree. However, we strongly oppose any attempt to mandate that insurance be purchased exclusively through a health alliance.

NALU and AHIA believe that mandating purchasing pools will have an adverse effect on millions of American, both in cost and services. Instead, should Congress decide that purchasing pools are an integral part of the health care program, these alliances will be

voluntary. We will not have destroyed the existing delivery system in the meantime. As in California, the participation in such purchasing cooperatives should be voluntary. More than 70 percent of the enrollees in the health insurance plan in California have chosen to use an agent, but also let the market compete alongside the cooperatives as in California.

The competition will help both markets, encourage cost savings, and provide our Nation's consumers with the best of all worlds. We are told by the Administration that voluntary alliances will not work because the threat of cherry picking and adverse selection. Mr. Chairman, we believe this prospect is unlikely, especially if we have insurance market reforms. If Congress chooses to extend coverage through employers, then nearly everyone will be in the system. Employers and their employees will have the ability to choose whether they wish to purchase from an alliance or directly from a company or through an agent. And remember, uninformed choice is a worthless choice here.

Choice, fairness, financial responsibility, and responsive to individual needs are all words and phrases that are critical to the health care reform debate. These concepts are keystones of a successful health insurance agent's commitment to his clients. They should be the mortar that cements the foundation of any health care reform. Thank you very much.

Chairman STARK. Thank you, Mr. Cunningham.

[The prepared statement and attachment follow:]

**TESTIMONY OF SAM J. CUNNINGHAM  
ASSOCIATION OF HEALTH INSURANCE AGENTS**

Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify this morning. My name is Sam Cunningham. I am an agent from Irvine, California, and currently serve as president of the Association of Health Insurance Agents (AHIA). AHIA, a conference of the National Association of Life Underwriters (NALU), represents some 9,000 professional insurance agents whose primary business involves health, disability and long-term care insurance. Founded in 1890, NALU is a federation of approximately 1,000 state and local associations whose members include over 143,000 professional life and health insurance agents throughout the nation.

Agents Support Health Care Reform

NALU and AHIA members support health care reform, and applaud this committee, other members of Congress, the President and others for their efforts to rationalize the health care delivery and financing systems. Each of the reform proposals currently pending has many strengths which we urge you to consider carefully—and enact the best into law. Among the reform measures that we encourage you to adopt are so-called insurance reforms which would subject all health care plans to guaranteed issue, guaranteed renewability, portability, limits on pre-existing condition requirements, administration and paperwork streamlining, and cost control measures. We understand the need to make sure that the reformed system's costs are as contained as much as possible, and the need for government involvement, especially in the provision of health care to underserved areas and low-income people. We agree that government involvement should enhance what is essentially a competition-driven, private system that guarantees full and free choice for all Americans. We also support an active employer role in the provision of health care coverage for all Americans.

Structure of Buying Groups

The President's health reform proposal, along with H.R.3222/S.1579 and the Senate Republican Health Care Task Force proposal, sponsored by Senator John Chafee (R-RI), makes a principal part of health care reform the creation and implementation of a "buying group." The buying groups are intended to consolidate the market power of many individuals and employees of small businesses; streamline administrative and paperwork requirements and realize substantial cost-savings as a result; and also to eliminate, or minimize, risk assessment (of individuals or small groups) as a basis for issue and/or price of health insurance coverage. In the Clinton proposal, the buying group is called a health alliance, and it would be the only way (i.e., it would be mandatory) for any individual or employer group of under 5,000 to purchase health insurance. Under the rules of H.R.3222/S.1579, the buying group is called a HPPC (health plan purchasing cooperative), with participation in the HPPC mandatory for individuals and for businesses of 100 employees or fewer. The Chafee plan sets up HPPCs, but makes them voluntary for all.

NALU/AHIA believe that to the extent the reformed health care delivery/financing system includes buying groups, participation in them should be voluntary. Buying groups are a largely untested, theoretical concept that may well prove to be effective—but there is also the possibility that unforeseen problems will develop and changes will have to be made. Thus, a period of "testing" the buying group concept, without imposing unnecessary risk to the current system of health insurance coverage, becomes an important safety net. This is what the states of California and Florida did in enacting health care reform. The professional agents represented by AHIA and NALU worked with California and Florida in creating their reforms, and are working with the states' buying groups now. We want to work with the Federal Government on reform as well, and also hope to be able to work with the buying groups, if they result from this reform effort.

A rule that makes participation in buying groups mandatory poses an unnecessary threat, and undercuts the safety net protection needed during the testing period. Because buying groups are built on a theory of market power derived from pooling many individuals, insurance plans must attract a large number of participants in order to compete. Because exclusive buying groups may not allow sufficient flexibility for small and medium sized insurance plans to market in such an environment, there is grave risk—indeed, a high likelihood—that due to capital requirements and market penetration concerns, many—probably most—small and medium sized insurers will be unable or unwilling to experiment in this new environment. If this happens, only a few, large insurance companies and/or provider networks will survive. This in turn will seriously undercut the safety net potential

allowed by rules that permit the private sector to compete—on a fair and open playing field. It will also substantially limit the choices available to consumers of health care services.

Further, there is substantial agreement both in government and in the private sector that competition is the key to the new system. The President, the authors of the principal Congressional health care reform proposals, health care providers and health care insurers all generally agree that costs cannot be controlled without vigorous, fair competition. The truth of this belief is just as applicable to the buying groups themselves. A buying group will be more responsive, more effective, more efficient and more likely to succeed in its mission of assuring quality, affordable health care to all comers if it is itself subject to full, free, fair competition.

It is important to dwell a moment on the phrase "full, free, fair competition." Neither the insurance coverage available inside the buying group nor insurance coverage available on the private market should be subject to competitive advantages derived from regulatory issues. If plans inside the buying group must provide guaranteed issue, guaranteed renewability, portability, limits on pre-existing condition exclusions, etc.—and they should—then, so, too must plans available outside the buying group be subject to these rules. Insurance reform is a crucial element of health care reform, regardless of the structure under which health care coverage is delivered to consumers.

The level playing field requirement guarantees that buying groups will not be subject to "cherry-picking," i.e., the practice of trying to identify the healthiest, best risks and thereby leave the less healthy people for others to insure. Some say that a voluntary buying group structure poses the risk of cherry-picking for the buying groups. Others argue that the risk is graver for insurance available outside the buying group. Neither is an acceptable result. Cherry-picking must be eliminated for this system to work.

We believe that the small group insurance reforms which we support will eliminate intentional cherry picking whether buying groups are created or not. However, to the extent Congress creates buying groups and believes that residual cherry picking problems remain, risk adjustment/reinsurance mechanisms which have been proposed to operate on insurance plans inside the buying group could be expanded to apply to all plans, whether available on the outside or inside the buying group.

We have collaborated with the Health Insurance Association of America in creating a rudimentary mechanism. The risk adjuster/reinsurance mechanism would mathematically adjust for claims experience among all health insurance plans. It would calculate a "risk adjustment factor" to account for consumers' use of insurance coverage. That factor would be used to increase or decrease the premium charged by an insurance plan—after the period of insurance—to smooth out inevitable "bumps" in claims experience. It also eliminates any incentive to save money on health insurance by the premium payers by trying to join or form a group composed of only young, healthy participants. In short, it eliminates any benefit from cherry-picking and as a result eliminates the practice itself. We would be happy to share our findings to date with the subcommittee.

#### Employers Should Continue to Play Vital Role in Health Care Financing

Currently, over 3/4 of all health insurance coverage is provided through employment. Most Americans and their families are covered through employer-provided (and usually paid-for, at least in part) health insurance. That crucial employer link between insurance and consumer continues under all the pending health care reform proposals. Employers are required to at least make insurance available, through the buying group at specified workforce size levels, to all their employees, and the President would require employers to pay 80% of the average, weighted premium for all their employees. Even where employers are not required to pay for coverage, they are required to allow payroll deduction of premiums paid to HPPCs to distribute to accountable health plans.

The reform proposals' recognition of the key role of employers in the health care financing system is well-placed. But it needs to focus on one additional element—employers. Whether or not employers are required to pay for health insurance premiums, they most often CHOOSE to pay at least a part of their employees' health care coverage. They have



a stake in effective, efficient health care delivery and cost. Their workers' productivity is affected, significantly, by this issue, adding yet another element to the bottom line of this country's economy from this issue. Employers must continue to be active participants in the selection process of affordable, quality health care and health care coverage. A buying group that is voluntary is the best way to accomplish this objective.

### The Agent's Role in Choosing Health Care Coverage

Historically, the agency system has been the principal method of distribution for private life and health insurance. Agents are the essential link between consumer—whether individual or business—and the insurance company, providing and servicing the products of the insurer while educating the consumer on how to manage risks and how to make informed choices regarding their insurance purchases. The need for this function continues under the proposals for reforming the system. Although all plans contemplate design and provision of "basic, comprehensive" packages of coverage, there will remain choice, and where there is choice, there is the need for informed, expert guidance in making that choice. Further, there will remain a third-party payment system. Insurance, in whatever form, will be paying for the bulk of a consumer's health care costs. Thus, the need to troubleshoot between the insurer and the provider, on behalf of the consumer, will remain. Therefore, the role of the agent remains.

The agent has proven to be, in most cases, the professional most able to provide expert guidance in making choices, as well as efficient resolution of claims or other problems between the provider and the consumer and the insurer, in the most cost-effective manner. The Managed Competition Act recognizes this with its explicit language allowing insurance plans to use agents. Even the Clinton proposal, despite its explanatory language that terms agents "outdated" and unnecessary, recognizes the need for advice and guidance in making insurance choices, especially for coverage beyond the basic, comprehensive package. Therefore, it is crucial to acknowledge that although some consumers will take the time and expend the energy to read detailed descriptions of plans and procedures, many, many more will want to be able to call upon a professional to help them sort through what is, after all, a fairly complicated and extremely important issue. We believe many consumers will WANT—and should be able—to keep working with their agents.

What does the licensed, state-regulated professional agent do?

- Professional health insurance agents work with clients to evaluate their need for health and other insurance protection. This may involve substantial research and fact-finding about the person's individual and family situation and the available products best suited to meeting the needs of those individual situations. This is an on-going process since needs continuously change as a person's family and employment situation change.
- Professional health insurance agents explain the various programs available and relate the elements and restrictions inherent in a given plan to the plan's costs.
- Professional health insurance agents encourage their clients to act in a timely fashion to assure that the proper coverages are in place when they are needed. They also see to it that accurate and complete information is provided to the insurer so that the client is sure to get the very best price or premium available.
- Professional health insurance agents keep in touch with their clients and review or update coverage on a periodic basis. They suggest changes when appropriate and counsel clients on ways to reduce cost. Often, they assist their clients in reviewing the need for legal and/or tax compliance, and recommend other professionals when assistance such as tax or legal issues arise.
- Professional health insurance agents assist with claims, answer questions and serve as ombudsmen in helping their clients deal with insurance companies and, often, with medical services providers. They help clients assemble proper documentation to file or follow up on claims, especially among those agents whose clients are Medicare beneficiaries.

- Professional health insurance agents assist business owners in communicating benefit packages to their employees, and often assist the employees in seeing how the benefits coordinate with their personal financial programs as well as those provided by government.

The helpful role agents play with small business firms was borne out by a poll (attached), commissioned by AHIA and done by Penn-Schoen this past autumn. The poll demonstrates that over 70% of small businesses who now provide health insurance to their employees like, respect and value the services they receive from their agents.

We believe that even after reform, someone will have to provide advice on how and what to choose in the way of the best health insurance coverage for each individual, troubleshoot problems between providers, consumers and insurers. Booklets, brochures, "report cards" and other documents; 800 numbers and other impersonal information sources will certainly work for some consumers. For most, such devices are simply insufficiently responsive to consumer needs. We need look only to the IRS and its documents and information telephone numbers for a lesson in how not to serve the consumer. To be truly responsive in a cost-effective way, the new system needs someone who will look out for the consumer. We believe that that someone should continue to be the someone who performs these tasks so well now: the professional, caring health insurance agent.

#### Tax, Cost Control, Product Design Issues Also of Some Concern

While AHIA/NALU are primarily concerned with the issue of devising the best structure for a reformed health care delivery system, we are also concerned with financing aspects of the reform plans. While we have historically supported tax incentives aimed at encouraging people to enjoy the security of adequate and appropriate insurance protection, we will not oppose provisions, such as a tax cap or an employer mandate, that go beyond encouragement and incentive, if such provisions are drafted appropriately narrowly and target accurately our mutual goal of assuring universal access to affordable, quality health care coverage.

However, we must note that insurance companies must be able to create the insurance products we all want all Americans to have. Thus, premium caps and, possibly, pricing restrictions such as pure community rating, to the extent that they make it impossible for insurance companies to offer adequate insurance products, will be a problem for the agents represented by AHIA and NALU. We support the companies in their efforts to work with government to design appropriate cost containment measures.

Mr Chairman, we appreciate the opportunity you have given us to testify here today and we look forward to working with you on this vital issue. For now, I would be pleased to respond to any questions that you might have.

Thank you.



Association of Health Insurance Agents

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**NOTE: Embargoed for Release Until September 14, 1993, 10:30 a.m. EDT.**

## HIGHLIGHTS

### NATIONAL SURVEY: SMALL BUSINESS CONCERNS ABOUT HEALTH CARE REFORM

#### Loss of Choice a Key Concern

- Well over three-quarters (83%) of small business benefits planners want their participation in government-sponsored insurance purchasing groups to be voluntary.
- Three-quarters (77%) agree strongly or somewhat that the private insurance market should be permitted to compete on a "level playing field" with the government-sponsored groups.
- Two-thirds (66%) would prefer to have many different benefits plans to choose from rather than trusting the government-sponsored insurance purchasing groups to provide a few basic benefits packages that will fit all.

#### Reluctance to Sacrifice Convenience

- Two out of three (66%) think Clinton's health care reforms will put more of a burden, not less, on businesses like theirs.
- Most (59%) expect large, government-sponsored insurance purchasing groups to provide worse, not better service than they now get from private insurers.
- Insurance agents are an important source of detailed information about the employee health care plan to 78% of small businesses surveyed.
- Eighty-four percent say the company's health insurance agent provides a useful service to their firm. Most of the companies surveyed rely upon agents to:
  - Make recommendations on the right plan (82%)
  - Negotiate policy renewal or a new policy (75%)
  - Tailor a health care plan to fit employees' needs (73%)
  - Review and deliver contracts (73%)
  - Handle enrollment and claims problems (69%)
  - Advise on employee contributions (54%)
  - Make changes or modifications in the plan (54%)
  - Monitor claims (51%)

A Conference of



The National Association of Life Underwriters

- Eight out of ten (79%) agree agents should continue to serve as a link between insurers and the insured.

#### Concerns About the Cost of Reform

- Opinions split on whether health care reform will bring down the cost of health care: Thirty-nine percent think health insurance will be more affordable under the new plan, but 43% say it will be less affordable.
- If the Clinton plan eliminates private insurance agents, most small businesses (52%) say they would be likely to have to make other arrangements, such as recreating the role in-house. Those surveyed say they might be forced to take such steps as: Hiring an outside consultant to administer their health plans (35%); expanding the department that handles their plans now (26%); or creating a department to administer their plans (13%).
- If taxes had to be raised to pay for health care reform, the most acceptable to this group would be a value-added or national sales tax (30%) and taxing employers who do not provide health care (35%). Least acceptable: A payroll tax on employers (4%) or employees (6%).
- A majority disagree strongly (41%) or somewhat (11%) that the tax deductibility of health benefits should be reduced.
- Small businesses think there should be a partnership between employers and employees in which both would be required to pay part of the cost of health care coverage, subject to their ability to pay: 66% agree strongly or somewhat.
- To ensure basic health care coverage for all, 62% of small business benefits planners say there should be government subsidies for low-income employers and employees.

**Summary Report on national opinion  
survey of small businesses concerning  
health care issues**

**Prepared by Penn + Schoen  
Associates Inc., on behalf of the AHIA  
September 14, 1993**

## Executive Summary

Small businesses want the right to choose between all options now available in the health care marketplace and any innovations, such as purchasing groups, that may come into existence. Better than three in four (77%) small businesses that offer their employees health insurance say that there should be both purchasing groups and a private insurance market that compete on a level playing field. Small business people see this as the best guarantee that cost savings, if any, will be realized from health care reform, and that the levels of service they now enjoy are preserved.

Small businesses are unconvinced that innovations such as purchasing groups will work as intended and that competition can actually be managed. For example, 43% say group purchasing power will mean less affordable coverage for small businesses, while 39% say that group purchasing power will make coverage more affordable for small businesses. Small businesses sense that health care reform means more costs and concerns than changes for the better. About two in three — 66% — say the burden for small businesses will increase with the Clinton Administration's health care reform plan. (Only 8% say the burden will decrease.) These underlying attitudes explain why small businesses that now offer health insurance so strongly oppose requiring participation in purchasing groups. Better than eight in ten (83%) small businesses oppose the government requiring small business participation in purchasing groups.

### **Concerns about service/role of agents**

Small businesses also worry that purchasing groups will not provide the same level of service they now get from agents or brokers. Specifically, better than three in four small businesses (78%) say agents or brokers are the most important way most of them now get detailed information about health insurance. An 84% majority of those small businesses that make use of agents say that they provide useful services, such as analyzing options in the marketplace, negotiating the plan renewal, or tailoring the plan to fit their needs. Overall, a 79% majority say that agents should continue to serve as links between insurers and the insured.

### **Choice between different types of health care plans**

Small businesses also want the right to choose between as many different types of health care plans as possible to ensure there is always an option that fits their particular needs. About two in three (66%) say they want many different benefit plans to choose from, rather than trusting the purchasing group to provide a few basic packages meant to fit all small businesses (29%). Small businesses with a gross income between \$1-5 million are even more concerned than other small businesses that there may not be options tailored to their needs.

### **Strong support for reform/attitudes toward taxation**

Small businesses now providing health insurance strongly support many proposed reforms of the health care system. For example, nine in ten (91%)

favor malpractice and tort reform. Another 86% support eliminating unnecessary medical procedures. Better than seven in ten (71%) favor caps on employer obligations for health care. If implemented by the Clinton Administration, these reforms would meet with strong approval from this segment of the small business community. Finally, about one in three (35%) small businesses that offer health insurance favor taxing employers who do not offer it to help pay for health care reform. Another 30% say they support a VAT or national sales tax to pay for reform.

## The findings

The following is a more detailed question-by-question analysis of the national survey of 410 small businesses that provide health insurance.

### Type of insurance

Small businesses offer a wide variety of insurance plans, and no one type predominates over the rest. About three in ten (31%) say they offer Blue Cross/Blue Shield, while 24% offer HMOs. Sixteen percent have commercial insurance, while 13% offer PPOs or preferred providers. Nine percent are self-funded.

**Table 1**  
**Type of insurance plan**

Blue Cross/Blue Shield	31%
HMO	24%
Commercial Insurance	16%
PPO	13%
Self-insured	9%



**Health insurance restructured or otherwise changed**

Many small businesses in the United States have changed or restructured their employee health insurance plans in the last few years. Four in ten (40%) have increased employee deductibles, while one in four (25%) have adopted a flexible benefits program ("Cafeteria" style). About one in five (21%) of small businesses that offer health insurance have changed to an HMO, and 18% to a PPO. About one in eight small businesses (12%) have become self-funded.

Most small businesses (55%) have their employees contribute to the health plan. Of those businesses with employee contributions, many (44%) have increased the employee contribution in recent years. Better than seven in ten (71%) of those businesses that have increased the contribution recently raised the employee contribution 25% or less.

**Other changes to make health care more affordable**

We asked an open-ended or verbatim question to learn if there were any other changes that small businesses had made to make health care more affordable. About one in five had either changed carriers, shopped around for a better price, or learned more about their options in the market place to make health care costs more affordable.

**Small businesses get information on insurance from agents**

We evaluated various ways small businesses in this country get information on insurance ("Is this a very important, somewhat important, not very important, or not at all important way to get detailed information about your employees' health care plan?") The most important way to get information is through a health insurance agent or broker. Better than three in four (78%) say this is an important way to get information. Fifty percent say agents are "very important". Only one in five (20%) say agents are not an important way to get detailed information.

The next most important way to get information is handouts or other materials that insurers provide — 72% say it is an important way to get information about health insurance. (Twenty-nine percent say handouts are "very" important for informational purposes, while 43% say handouts are "somewhat" important.) A 65% majority say that a toll-free 800 number is an important way to get detailed information. ...Direct mail from insurers tends to be the least important way to get information, with 34% who say direct mail is an important way to learn the details.

**Feature of current plan employees like best**

We asked an open-ended or verbatim question to determine which feature of the current plan small employees report that they like best. One in five (20%) like being covered or aspects of their coverage ("coverage," "coverage is good once deductible is met," "additional dental," etc.). Other common responses concerned the lack of paperwork (9%), flexibility (7%), and prescription coverage (6%).

**Provision of specific services by agents/brokers**

A 72% majority of small businesses that now provide health insurance say agents are important for the information they provide. Another 9% say that the information they provide is not very important, while 18% say the information is not at all important. The following is an evaluation of the service provided by agents in terms of specific tasks. (The 18% who say the information is not at all important did not evaluate agents on these tasks.)

**Table 2**  
**Did agent/broker provide this service?**

<b>Specific task</b>	<b>yes</b>	<b>no</b>
Analyze options in market	82%	16%
Negotiate renewal	75%	23%
Review and deliver contracts	73%	24%
Tailor plan to make it fit employees' needs	73%	25%
Handle enrollment and claims	69%	29%
Meet or talk to employees about plan	65%	34%
Make changes or modifications in plan	54%	43%
Advise business owners on employee contribution	54%	41%
Monitor claim experience	51%	37%
Help you with various gov't forms, paperwork	39%	53%

We also asked respondents to evaluate their agents performance on each task outlined above. Between 91% and 96% of small businesses say their agent did a good job on any particular task.

**If no agents, what would your business do?**

A 52% majority say that their small businesses would need to make adjustments if there were no agents or brokers. Four in ten (40%) say they could provide the same service if there were no agents or brokers. The solution for many small businesses would be to hire someone to do many of the same

things that agents do now. Better than one in three (35%) say they would hire a consultant to do what agents handle now. Another 26% would either expand the department in their business that handles health care now or create a new department (13%). Of the nearly six in ten small businesses that would need to make changes of some type or another, 53% say they would not need to hire anyone new, while 36% say they would hire one person, and eight percent say they would hire two or more people to compensate for the work now performed by the agent.

### **Agent compensation**

Half of all small businesses do not know how much the commissions are for health insurance agents (50%). Another 38% say the commission is between 1%-10% percent, while another 10% say the commission runs between 11%-20%. Once we inform respondents that commissions average between 4%-6%, almost two in three (67%) say the price is fair. Twenty-three percent say the price is unfair.

## **Perceptions of managed competition**

We examined whether small businesses believe that health care reform by the Clinton Administration will mean a greater or lesser burden on them. We also examined attitudes among small business in America toward purchasing groups, and some of the possible effects this critically important aspect of managed competition will have in terms of providing health insurance.

### **Clinton program: perceived burden on small business**

Almost two in three (66%) say the Clinton Administration will put more of a burden on small businesses. About one in twelve (8%) say the burden will lessen. While majorities of small businesses of every size say the burden will increase, those businesses that employ 51-100 persons are especially likely (79%) to be concerned about new burdens. Businesses with self-funded health insurance (75%) are also more likely to say there will be a greater burden.

### **Prefer voluntary participation in purchasing groups**

Better than eight in ten (82%) small businesses that now offer health insurance oppose the government requiring small business participation in purchasing groups. Another 13% favor requiring participation in purchasing groups. While majorities of small businesses of every size say they oppose required participation in purchasing groups, those businesses that employ 51-100 persons are less likely to support the mandatory concept (9%) than businesses with 10 or fewer employees (20%).

### **Prefer many different plans to choose from**

Small businesses prefer (66%) to have many different benefit plans to choose from, rather than trusting the purchasing group to provide a few basic packages (29%). Those small businesses that gross less than \$5 million are concerned that a more limited set of options will not fit their particular needs. For example, seven in ten (70%) small businesses with a gross income between \$1-5 million prefer choice, and 22% say a basic package is acceptable. Small businesses that gross more than \$5 million annually are somewhat more comfortable with the idea of a few basic health care options provided by a purchasing group. (Though a majority still oppose the concept of a few basic health care packages to fit all small businesses.) Forty-two percent of those businesses that gross more than \$5 million favor a basic package, while 56% prefer to have many different plans to choose from.

### **Purchasing groups will not provide service agents do now**

Small businesses also say the purchasing groups will not provide the same level of service that agents provide now. Fifty-nine percent say that purchasing groups will provide worse service than agents, while 17% say purchasing groups will be able to provide better service. Another 11% volunteer that the level of service will probably be about the same. Small businesses that gross between \$1-5 million annually are more likely (67%-12%) to say that purchasing groups would not provide better service than agents. The small businesses with gross incomes over \$5 million agree (55%-28%), that purchasing groups would not provide better services.

**Uncertain whether group purchasing power means lower prices**

Small businesses are split on the idea of whether group purchasing power will actually mean more affordable coverage or not. About four in ten (43%) say purchasing groups will mean less affordable coverage, while 39% say purchasing groups mean more affordable coverage. Four percent volunteer that it will mean no change in prices. Businesses with fewer than 10 employees are more likely (47%-29%) to say that a purchasing group will mean more affordable coverage. Businesses with more than 50 employees are more likely to say that there will be less affordable coverage (48%-33%). Rural companies are also more likely (51%-31%) to say coverage will be less affordable because this arrangement will mean less competition in the private insurance market. Southern small businesses (47%-30%) are also more likely to say there will be less affordable coverage, while Northeastern firms (45%-35%) are more likely to say there will be more affordable coverage.

**Ideas for reform**

We tested various ideas for reforming the nation's health care system to learn about the attitudes and concerns of small businesses nationally that already provide health insurance to employees.



**Table 3**  
**Ideas for reform**

<b>Type of reform</b>	<b>agree</b>	<b>disagree</b>
Malpractice, tort reform	91%	5%
Eliminate unnecessary medical procedures	86%	8%
Wellness programs	87%	12%
Agents as link	79%	17%
Level playing field with both private insurance and purchasing groups	77%	17%
Caps on employer financial obligation	71%	24%
Employee/employer partnership to pay costs	66%	30%
Gov't subsidies for low-income employees to ensure basic health care	62%	23%
Reduced tax deductibility	40%	52%

#### **Tort reform/Eliminate unnecessary medical procedures**

Better than nine in ten businesses agree that malpractice and tort reform are important to cut the cost of litigation associated with health care. A 91% majority agree, while 5% disagree. Eighty-six percent of small businesses say eliminate unnecessary procedures. Eight percent do not see this as a major part of the reform process.

#### **Agents as links/Level playing field**

Seventy-nine percent say that agents should continue to serve as links between insurers and the insured. Seventeen percent disagree. Better than

three in four (77%) small businesses that now offer health insurance to their employees say that there should be both purchasing groups and a competitive private insurance market on a level playing field. Seventeen percent disagree.

### **Wellness**

Better than three in four (77%) say tax incentives for wellness programs and other prevention programs should be part of health care reform. Twelve percent disagree.

### **Caps on employer financial obligations**

Seventy-one percent say that there should be caps on employer obligations for health care, while 24% disagree.

### **Partnership between employer and employees so each pay part of the cost of health care**

Almost two in three — 66% — favor a partnership between employers and employees in which both would be required to pay the cost of health care coverage, subject to the ability to pay. Thirty percent disagree.

### **Subsidies to ensure basic health care for everyone**

Better than six in ten (62%) businesses favor government subsidies for low-income employers and employees to ensure everyone has some basic health care.

**Oppose reduced tax deductibility of health insurance benefits**

More than half (52%) oppose the idea of reduced tax deductibility of health insurance benefits, while 41% favor a reduction to help pay for health care reform.

**Taxes**

If there must be new and higher taxes, small businesses favor either taxes on employers (35%) who do not now provide health care or a VAT/sales tax (30%). Sixteen percent volunteer "no taxes" when asked this question.

**Owner or employee benefit person**

Almost three in four (74%) small business persons interviewed are employee benefit or other employees primarily responsible for employees' health insurance. Twenty-six percent are owners.

Chairman STARK. Mr. Katz.

**STATEMENT OF ALAN KATZ, PRINCIPAL, CENTERSTONE INSURANCE AND FINANCIAL SERVICES AND LEGISLATIVE CHAIRMAN, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS**

Mr. KATZ. Thank you, Mr. Chairman. My name is Alan Katz. I am Legislative Chair of the National Association of Health Underwriters. Our members have a unique view of the health insurance reform debate, for every day we see firsthand what is working in the current system and what needs to be changed. That is why Health Underwriters developed a comprehensive reform package called Real Choice. Its goal is to provide universal access to affordable health care through a stable and fair marketplace.

It has much in common with many of the proposals before Congress, including the Administration's plan. It changes the way carriers do business so they have to manage risk, not avoid it; it reduces paperwork and contains cost. These similarities and others are described in our written testimony. I would like to discuss two of the issues where we differ with the Administration, starting with the issue of health alliances.

For the record, Health Underwriters questions the necessity of government-sponsored purchasing pools. However, we appreciate the desire of members of both parties to experiment with such arrangements. The issue then is, if there are to be health care alliances, should they be the exclusive outlet for plans available in a region?

We believe that private alliances competing with public alliances will serve consumers better. Exclusive health alliances, free from competitive pressure, lack the incentive to provide the quality service and performance American consumers have the right to demand. Exclusive, health alliances are the equivalent of the company store that leaves consumers no viable alternative but to take what they get.

That is why the Jackson Hole group recently reversed its position in support of exclusive purchasing pools and now rejects them. Health Underwriters also recognize that health alliances are experimental. They may not work.

If alliances must compete with private carriers, consumers cannot lose. Whichever model best meets consumer needs will prosper. However, if this Congress establishes exclusive health alliances and if those health alliances fail, an entire infrastructure will have been dismantled. It represents health care reform without a net. And the folks who could get hurt the worst by a fall are American consumers. These are among the reasons that seven of the eight States that have passed purchasing pools have established voluntary ones.

Health Underwriters also disagrees with the Administration as to the role of agents in a reformed system. They seem to view us as part of the problem. Not surprisingly, we view ourselves as part of the solution. We do not believe an 800 number or government manual can replace the hands-on, personalized advice and independent advocacy that agents provide their clients. For millions of small businesses, we are the only human resources department

they can afford. Further, agents' primary loyalty is to our clients. If we don't deliver, our clients can fire us at any time.

The same cannot be said for the employees of an exclusive health alliance. Eliminating agents does not eliminate the need to have someone answer consumer questions and solve their problems. The issue is, will answers and solutions be provided by an agent that knows the consumer, that is accountable to the consumer, or by a full time alliance employee who has never met the consumer and owes her no loyalty?

In California, employers are voting for agents with their pocket-book. Of the nearly 1,200 small businesses that have already signed up with the State's voluntary health alliance, 79 percent chose to use an agent even though doing so adds, on average, 5 percent more to their bill each month.

You had a conversation with an earlier witness that discussed problems that agents have caused and Health Underwriters has been very active in trying to encourage enforcement against the bad players in our marketplace. We recognize that agents play a crucial fiduciary role with their clients, and they have to be the kind of professionals, both agents and consultants, that American consumers have the right to expect.

Health insurance agents can play an important role in passing meaningful, comprehensive health care reform during this Congress. Agents are active in communities throughout this country. We coach Little League and chair the PTA. We lead charitable organizations and head chambers of commerce. We can reach out literally to millions of Americans, our clients and employees.

The professionals that make up the National Association of Health Underwriters stand ready to use these positions of influence and our insight into the system to work with you and the White House to resolve our differences and achieve health care that not only is always there, but health care reform that always works. Thank you.

Chairman STARK. Thank you very much.

[The prepared statement and attachment follow:]

TESTIMONY  
of  
**ALAN KATZ**

LEGISLATIVE CHAIRMAN  
**NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS**

before the  
**Subcommittee on Health  
Committee on Ways and Means**

November 5, 1993

Mr. Chairman, Mr. Thomas, Members of the Committee, I thank you for the opportunity to appear before you today to discuss the Administration's proposal for health care reform, particularly the issues surrounding the proposed regional health alliances.

My name is Alan Katz. I am a principal in a Centerstone Insurance & Financial Services, Inc., a general agency in Los Angeles, California specializing in the health insurance market. In addition, I am Legislative Chairman of the National Association of Health Underwriters (NAHU), a member of the NAHU Board of Trustees, and Immediate Past President of the California Association of Health Underwriters (CAHU). With almost 15,000 members, NAHU is the largest and the only independent association representing insurance professionals specializing in health insurance in the United States.

Our nation faces a unique opportunity to reform our health care system, an opportunity made possible through the leadership of President Clinton. The President and the First Lady deserve credit for placing health care reform at the top of our country's agenda. They also deserve credit for advancing the cause of universal access to affordable health coverage, a goal NAHU strongly supports.

NAHU supports the bulk of the President's plan and looks forward to a constructive debate. We are confident that we can resolve those points of disagreement -- most significantly the nature and structure of the alliances that are the subject of this hearing -- and achieve in the near future, meaningful health care reform that works for the American consumer.

NAHU has long supported comprehensive market-based reform of the health insurance market. We developed our position after years of experience when, as consumer advocates and advisors, we were forced to inform our clients that their health coverage was canceled; or that it would no longer be affordable; or worse, that we could not find coverage suitable to their needs.

The debate over uninsurable and underinsured Americans is not only a matter of statistics for us; we personally work with these individuals on a daily basis to obtain affordable coverages. They are not just our clients: they are members of our community, our friends, our neighbors, and in many cases, our families. Sometimes -- too many times for us -- we come up short. Agents believe in reform.

NAHU believes there is much that is good about America's system of health care coverage today. What works now should be maintained. What doesn't work must be reformed. NAHU is committed to comprehensive and responsible health care reform providing universal access to affordable, high quality options in a competitive health care system.

Since the 1980's, NAHU has been on record in favor of market-based reforms that will achieve the six principles of reform that President Clinton has put forward: security, simplicity, savings, choice, quality and responsibility. We have repeatedly offered our strong support for these principles.

Our early commitment to reform evolved into NAHU's comprehensive *Strategy for Health Care in America*, first developed in 1990. In light of the continuing need for health reform, that *Strategy* was revised in May of 1993 and re-introduced into the reform debate as *REAL CHOICE*, a comprehensive strategy for health reform. *REAL CHOICE* is based on the NAHU's *Consumer Bill of Rights*, and copies of both are appended to my statement

#### NAHU's PLAN v. THE CLINTON PLAN

NAHU's plan, like the Administration's plan, proposes universal coverage for all Americans. Under the Administration's approach, exclusive government-sponsored health alliances would negotiate with carriers to offer coverage in a region or state. Consumers employed in firms of less than 5,000 employees (and many in larger firms) could purchase their coverage only through their one local health alliance.

The nature of the exclusive health alliances included in the Administration's legislation is somewhat less restrictive than originally proposed in September. NAHU applauds this move towards more competition, but we urge them to move further still. As representatives of the Jackson Hole group noted in testimony (reversing the group's previous position) before the Senate Labor and Human Resources Committee on October 20, 1993, the absence of competition between alliances will almost inevitably lead to a highly bureaucratic organization with a tendency to serve its own interests rather than those of its members.

NAHU's plan places greater reliance on competition. NAHU calls for a system of multiple private alliances, voluntary in nature, all competing in a well-regulated market that features a level playing field. If alliances compete on a level playing field with existing carriers and *succeed*, consumers will win. If alliances compete and fail to match the efficiencies of the private marketplace, *consumers will still win* because the reformed marketplace has met their health coverage needs. The marketplace should decide the effectiveness of this new mechanism for the time-proven concept of pooled purchasing power.

NAHU also differs with the Administration with respect to the standard benefits package. The Administration's "one-plan-fits-all" approach eliminates consumer choice and places the government in the paternalistic role of determining what consumers want and need from their health plans. It also will result in tremendous political battles over what is in the plan -- and what is not.

NAHU believes that Americans should determine the plan design that best fits their families' needs. Instead of creating a standard plan for all Americans, we propose defining an essential benefit package that all plans must include, while permitting carriers the flexibility of adding additional benefits to meet market demand. To achieve the President's principle of simplicity, common definitions of benefits could be established so consumers could easily understand what their premium dollars are buying.

Under both the Administration's and NAHU's plans, companies would be permitted to fully deduct the cost of their plans. However, under NAHU's plan, employer-provided benefits beyond the essential benefit package would be considered taxable income to employees. This is aimed at controlling costs and encouraging responsible consumer purchasing decisions.

An additional area of contrast comes in the context of mandating coverage. The Clinton Administration proposes to build on today's predominantly employer-based system to require employers to pay 80% of the cost of coverage (within limits) for each employee and dependent.

NAHU also builds on the employer-based system by requiring employers to offer, but not to pay for their employees and employees' dependents' coverage. Instead, NAHU's plan would require individuals to purchase coverage. Subsidies in the form of refundable tax credits or vouchers would be available to assist low or moderate income individuals. NAHU proposes a full subsidy

for up to 200% of the poverty level (about \$28,000 for a family of four) and a partial subsidy for up to 250% of the poverty level

Both plans would require comprehensive carrier reform. Both plans require guaranteed access, guaranteed renewability, and fully portable benefits for every American.

It is worth noting that 31 states have already enacted guaranteed access provisions and 44 states have enacted provisions promoting portable benefits. These state reform efforts are benefiting consumers throughout this country and should be encouraged in those states that have not yet enacted market reforms.

NAHU and the Clinton Administration also agree on the need to reduce paperwork. Both plans standardize claims and applications forms, and would move towards paperless transactions.

One area of significant difference between NAHU and the Administration is price controls. Under the Clinton plan, if spending exceeds targets, caps on spending would be implemented.

Although insurers and providers would also be adversely affected by price controls, we fear consumers stand to lose the most under caps or global budgets. With respect to the Clinton proposal, "health security" or "health care that is always there" is undermined if access to care is rationed, and simplicity is sabotaged when incentives for gaming the system come to dominate. In addition, price controls in other areas of the economy failed to work for former Presidents Nixon and Carter; there is absolutely no reason to assume that they will work now. Market-based incentives are more likely to control costs than price caps.

Finally, the Clinton Administration and NAHU differ dramatically on the appropriate role of the professional agent in the health care system. The Administration proposes that alliances maintain exclusive control over the marketing of approved health plans. Agents are to be replaced by printed report cards on participating plans, interactive media, and advertising.

We do not believe any "1-800" number, gray government manual, interactive technology, or any other new system can adequately replace the hands-on, personalized advice and independent advocacy that agents provide to their clients. Although the Clinton Administration wants to believe insurance agents are part of the problem, we believe, health insurance agents are actually an important part of the health care reform solution. Perhaps the Administration is not aware that:

- Agents help more than 200 million Americans gain access to health care security.
- Agents are the consumers' advocate fighting bureaucracy -- public or private -- to get consumers the benefits they deserve.
- Agents are the "employee benefits department" for millions of small employers who cannot afford a full-time human resources department.
- Agents are cost-effective, compensated only when clients consider them valuable. Agents can be fired at any time the client is dissatisfied with their service.

Consumers are aware of this reality. Consider the evidence from my own state of California. Under legislation authored by Assemblyman Burt Margolin, California's health alliance began operations on July 1 of this year. That health alliance, known as the Health Insurance Plan of California (HIPC) is open to small businesses with five to 50 employees. Already over 1,000 California firms have signed up for the state's new health alliance. More than 78 percent have specifically chosen to enroll through agents.



The state agency overseeing California's HIPC recognized that agents add value to products we sell and service. Small employers are voting with their pocketbook that they agree. These business owners recognize that professional agents do far more than merely sell health insurance. Rather, we spend the majority of our time servicing our clients. Consumers will always have questions and, regardless of the best intentions, they will always face problems. Agents are who consumers turn to -- and want to turn to -- for answers and solutions. Agents who meet the ongoing needs of their clients succeed. Those who don't get fired. It is that simple.

Still, NAHU does not insist that all health plans be required to distribute and service their products through agents and brokers. We simply believe that health plans should not be prevented from employing agents and brokers when they choose to do so. Whether to use "W-2" employees or "1099" agents should be a business decision left to the carrier -- or health alliance -- and not subject to micro-management through legislation.

In sum, both the Administration's and NAHU's plans seek to provide universal access to affordable health care and to reduce the increase in overall spending on health care. Both reject an exclusively government run system by relying on private carriers and providers. The most significant area of disagreement, however, lies in the respective degree of government intervention into the marketplace.

### **HEALTH ALLIANCES**

The Administration can easily accomplish its objectives without creating exclusive purchasing cartels. Yet, they have articulated an inflexible position on this issue, so allow me to explain why they will not work as the Administration has proposed and what can be done to improve them -- without creating new government bureaucracies and without the government making the leap from regulator to competitor in the marketplace.

Members from both parties are interested in experimenting with purchasing pools. If health alliances are to be part of the ultimate reform package, NAHU urges Congress to recognize that they are experimental and treat them accordingly. We strongly urge that any and all health alliances be privately organized and voluntary in nature and be required to compete on a level playing field with other health alliances and with private carriers operating outside the alliance structure.

This is the approach taken by seven of the eight states that have already passed legislation establishing health alliances. It is how the nation's first operational health alliance, the Health Insurance Plan of California, operates. And it has several advantages over the exclusive health alliance model.

When health alliances compete on a level playing field with private carriers they have a strong incentive to provide top quality customer service. If they fail to do so, they lose business. Exclusive health alliances have no such incentive. This reality has led the Jackson Hole group to recognize that they were wrong in calling for exclusive purchasing cooperatives.

When health alliances compete on a level playing field with private carriers they tend to improve the offerings of private carriers and are forced to improve themselves. Competition between the California health alliance and the private sector has improved both the state plan and private carriers.

When health alliances compete on a level playing field with private carriers they have the chance to prove themselves -- without endangering consumers. Health alliances are experimental. They may thrive or they may fail. If they thrive by better meeting the needs of consumers, consumers win. If they fail, it means that entrepreneurs are better able to meet the needs of consumers, and consumers still win. Voluntary alliances are the only sure way to guarantee that consumers come out ahead regardless of the results of the experiment.

Proponents of exclusive health alliances will argue it is the only way to eliminate adverse risk selection. However, this argument fails to recognize that health alliances are to be created within the context of other far reaching reforms, most notably the requirement that all health plans be made available to all consumers regardless of their risk factors. If health alliances and private carriers offer products containing the same essential benefits and on a guaranteed issue basis, there is no reason why the health alliance should receive more than its share of high risk individuals.

The necessary mechanism for adjusting any remaining risk between health plans operating in a system of multiple voluntary private alliances is identical to that envisioned under exclusive health alliances. There is no need to duplicate this expertise from alliance to alliance; rather, state departments of insurance -- somewhat ignored under the Clinton plan -- can serve in this role.

There is also no reason why meaningful, comprehensive health care reform cannot be achieved in this Congress. The challenge is great, but so is the need for action. NAHU has offered a recipe for change that has numerous elements in common with the Administration. We stand ready to work with you and the White House to work through our differences.

Thank you for your attention and I will be pleased to respond to your questions.

# **REAL CHOICE**

**Universal Access**

**to**

**Affordable Health Care Coverage**

**The National Association of Health Underwriters'**

**Plan for Comprehensive Health Care Reform**



## **HEALTH CARE REFORM CONSUMER BILL OF RIGHTS**

### **National Association of Health Underwriters**

The National Association of Health Underwriters is committed to comprehensive reform that builds upon the strengths of the American health care system to provide all consumers with accessible, affordable care.

NAHU believes consumers have certain rights regarding medical care, which any reform program should protect. These rights are:

- (1) The right to guaranteed, uninterrupted coverage of essential medical care.
- (2) The right to affordable coverage and care based on fair and reasonable pricing practices.
- (3) The right to know the costs of proposed health care treatments and insurance coverage before they are delivered.
- (4) The right to select from among quality health care providers with whom consumers can build long-term relationships.
- (5) The right to treatment through proven medical practices based upon scientific outcome research.
- (6) The right to select health care coverage from among qualified insurers, properly regulated to assure financial security and prudent management.
- (7) The right to seek expanded coverage and care in the open marketplace.
- (8) The right to tax deductibility of all costs of an essential medical package.
- (9) The right to the innovations and quality of a competitive, privately based system of health care and coverage.
- (10) The right to seek professional consumer counselors and advisors in selecting coverage and obtaining benefits.

### **Implementing Goals**

NAHU believes these rights can best be delivered in a cost-effective manner to American consumers only through a restructuring of the nation's health care system. The new plan should build on the strengths of our current system while expanding access and constraining costs.

This new structure would provide universal coverage of all Americans through a fair and stable marketplace in which consumers have a variety of choices among affordable health plans.

It is this emphasis on choice that differentiates NAHU's recommendations from many other reform proposals. A single payer system would give government complete control over the health care of American citizens. Even Managed Competition as originally proposed by the Jackson Hole Group, while permitting consumers to choose among competing health care providers, restricts consumers to the care and services of a single purchasing pool.

NAHU believes a better means of achieving the common goal of universal and affordable coverage is through a system of competing providers *and purchasers* of health care coverage in a marketplace characterized by a level playing field. The decisions of well-informed consumers should police the marketplace and determine the best possible health care choices, not decrees of public or private bureaucracies.

To that end NAHU proposes a plan of REAL CHOICE. REAL CHOICE is a proposal that eliminates abuses; brings economic incentives to consumer medical care purchasing decisions; establishes mechanisms for appropriate governmental regulation; promotes the elimination of administrative inefficiencies; and preserves choice for each American in meeting personal health care needs.

### **Components of the REAL CHOICE Plan**

NAHU's REAL CHOICE plan envisions:

#### ***Multiple Voluntary Purchasing Pools***

Health care coverage is available to employers and individuals through traditional health insurance carriers (including health maintenance organizations) and multiple local health alliances. Unlike traditional plans such as Multiple Employee Trusts which usually offer enrollees coverage through only one or at most two providers, each local health alliance negotiates with and selects health plans that compete for membership among the alliance's enrollees.

REAL CHOICE seeks to create a system that preserves consumer options and promotes marketplace fairness. Therefore, participation in local health alliances by carriers and consumers is voluntary. NAHU opposes the creation of government sponsored or operated local health alliances, but where they exist, they should compete on a level playing field with private sector health care plans. Guaranteed access, renewability, limits on pre-existing condition exclusions and other carrier reforms apply equally to private sector carriers and local health alliances.

Local health alliances are an experimental form of health care delivery, untested anywhere in the world. Several states are now in the process of establishing different versions of purchasing pools. The National Health Board (NHB, described more fully below) will monitor these state experiments to measure their effectiveness at reducing costs and increasing access in comparison to efforts by private carriers. After no more than three years of study, and annually thereafter, the NHB will publish its findings.

#### ***National Health Board***

A National Health Board oversees the health care system. Recognizing that decisions of consumers in the marketplace can most effectively determine the best possible health care choices, REAL CHOICE limits the NHB to those tasks that require national monitoring. The NHB shall:

1. Establish an essential benefits package for purposes of determining tax deductibility;
2. Publish outcome studies and establish practice parameters (see Cost Containment below);
3. Establish minimum financial and operational guidelines to assure consumers of health care coverage provider solvency and capability;
4. Recommend enabling legislation to level the playing field among providers, payers, and purchasers of health care. In cooperation with the National Association of Insurance Commissioners, the NHB also helps develop common definitions for key policy terms and requirements such as "reasonable and customary," "co-insurance," "stop-loss" and "out-of-pocket maximum" to reduce consumer confusion regarding benefits.

### ***Basic Benefits***

The NHB will develop a list of core medical services which, at a minimum, must be covered by every health care program. The NHB also establishes an essential benefits package or packages which cover only core services and with cost not to exceed the maximum tax subsidy. An essential benefits package must be offered by all local health alliances and carriers. Carriers and local health alliances may offer any additional plan design. No local health alliance or carrier may be required by state legislatures to provide benefits not specifically required by the NHB.

The NHB also establishes maximum co-payment schedules for subsidized consumers (those at or below 200% of the poverty level). The need for Medicaid will be systematically eliminated. Consumers are free to choose higher co-payment levels with access to tax-free Medical Savings Accounts to assist in financing their additional expenses.

### ***Tax Subsidy***

People earning less than 200% of the federal poverty level will receive an advanceable refundable health insurance tax credit equal to the cost of an essential benefits package. Above 200% of the federal poverty level, the credit is phased out. The credit is refundable meaning that even those people who owe no taxes will still receive the health insurance tax subsidy.

### ***Tax Deductibility***

The entire cost of health insurance is tax deductible for any business, whether corporation, partnership or sole proprietorship. Any premium paid by an employer in excess of an essential benefits package is taxable to the employee. Premiums paid by an individual for any essential benefits package are tax deductible. Through their tax free status, Medical Savings Accounts encourage consumers to save for medical expenses and buy cost-effective care.

### ***Guaranteed Access, Renewability, & Portability***

No group or individual may be denied coverage by any carrier or local health alliance based on occupation or health status. Rate surcharges based on risk factors will be limited. No exclusions for pre-existing conditions are permitted when an insured maintains continuous coverage and has satisfied a one-time, six-month waiting period. All coverage is guaranteed renewable and has portable. A method permitting all carriers to reinsure their risks will be established.

### ***Consumer Advocates***

Today, consumers have access to independent insurance agents who provide information on carriers and benefits, handle grievances, and answer consumer questions. Moreover, consumers can select, change or fire their own agents at any time. REAL CHOICE recognizes that no "800 number" can replace the hands-on, personalized advice and independent advocacy that agents provide. Some proposals, such as the Managed Competition model, remove this consumer benefit by limiting individuals to the services of a single local health alliance. REAL CHOICE keeps this power in the hands of consumers by requiring that those who sell or give advice concerning the purchase of health care coverage be licensed and regulated professionals.

### ***Cost Containment***

REAL CHOICE recognizes that the only long-term means of restraining health insurance premiums is to constrain health care costs. Therefore, REAL CHOICE calls for the NHB to:

1. Develop standard medical practice guidelines and establish outcome studies as tools for cost-effective treatment and for determining essential levels of care. These outcome studies are published on an annual basis to educate consumers regarding the quality of care available from providers.
2. Require the disclosure of the cost of services to patients in advance of treatment to permit them to compare the cost of medical services to be purchased.

3. Establish limits on referrals by providers to facilities in which they have an ownership interest.
4. Establish methods of uniform and paperless claims transactions to be used by all payers of care.
5. Create a standard, consumer-friendly application for coverage forms to be used by all carriers and local health alliances.
6. Require mediation or arbitration prior to trial of all medical malpractice suits and limit awards in excess of actual damages to the plaintiff

### ***Health Security Card***

Every American will receive a Health Security Card from their payer which will facilitate immediate provider payment. Standards for electronic claims processing will be developed. It will also make health history immediately available to health care providers through an electronic data interchange although privacy considerations will be protected.

### ***Cost Disclosure***

To help consumers make purchasing decisions, the NHB will establish Comparison Schedules for all medical services. Doctors and hospitals will be required to disclose to the NHB their charge for each service. The NHB will publish the charges and the percentage difference of those charges from the Comparison Schedules. The NHB will make those charges, percentages, and provider outcome results readily available to all consumers. Carriers and local health alliances will be required to publish the percentages of the Comparison Schedule their policies reimburse Fee-For-Service providers for each service covered. By making comparisons, consumers will be able to help control their out-of-pocket expenses. The resulting marketplace pressure will act to limit prices.

### ***Requirements To Purchase Coverage***

REAL CHOICE requires all consumers to participate in the health care coverage system. Employers are required to offer coverage and maintain payroll deductions. Employees declining their employer's offer must purchase qualifying individual coverage through a local health alliance or a private carrier. Low income and indigent Americans will receive refundable tax credits on an income-graduated scale to subsidize their payments or payments made on their behalf.

### **REAL CHOICE: Affordable, Accessible**

The REAL CHOICE strategy preserves the benefits of a free market system while advancing access to affordable health care. It recognizes that the cost of health care is ultimately paid by consumers. It is sensitive to the ability of consumers, both individually and in the aggregate, to pay for that care. It also permits the orderly development of workable changes to minimize disruption and maximize consumer choices.

REAL CHOICE will result in comprehensive reform making health care coverage affordable and accessible to everyone without destroying a system that currently works extremely well for the vast majority of consumers.

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Chairman STARK. Mr. Gummere.

**STATEMENT OF JOHN GUMMERE, CHIEF EXECUTIVE OFFICER,  
PHOENIX HOME LIFE MUTUAL INSURANCE COMPANY**

Mr. GUMMERE. Mr. Chairman, we offer employee benefit coverages, primarily small employers—85 percent of our medical insurance customers are employers with fewer than 50 employees. The small business segment of the market is volatile, cyclical and has unique needs. We have demonstrated we know how to manage it. Our strategy is to work with these small businesses to provide high quality health care in a cost-effective way.

Our total annual group premium is about \$1.5 billion. We are small, efficient, and skilled in dealing with small businesses. Our average small business customer has been with us for close to 10 years, a long time given the normal practice of churning within the small group insurance marketplace. These facts we believe are a testament to our good value and excellent service.

Contrary to our critics' claims, we have not been profiteering on health insurance. In fact, for medical insurance alone, during the past 20 years, we have had a loss of 2.5 percent of premium.

Our after-tax profits on all lines of group insurance were a modest 3.4 percent.

Phoenix Home Life strongly supports comprehensive health care reform and supports several elements of the President's proposal. Most importantly, we agree with the President that there needs to be a mandate that all Americans must have coverage. We prefer that the mandate be placed on the individual where, like car insurance, everyone must obtain and maintain a minimum amount of coverage.

Our primary objection to the President's plan, and what I would like to focus on here today, is the President's proposal for exclusive health alliances. While we support the concept of health alliances, and we believe they should be a part of whatever reform package is enacted, we do have doubts about the design envisioned in the proposal.

Our objection really is based on three concerns: Exclusive alliances are unproven and untested; the plan will lead to a few carriers dominating the market; and, last, the administrative complexity of the system, will increase.

Only a few States have enacted the legislation to allow for the creation of purchasing alliances. All of them have provided for voluntary alliances. We think that implementing exclusive health purchasing alliances on a national scale without adequate pilot experimentation is very risky.

Exclusive alliances will eventually result within a few short years in domination by a few giant health insurance companies and HMOs in the health care market. Such a concentration of control in the market is not good news for consumers.

The system will create lumbering giants that make money for their owners but will turn out expensive and increasingly poor quality products for the consumers. The market would lose the innovative and cost-efficient competitive pressure that the hundreds of small and mid-sized insurers provide. Instead, success within the alliance may depend more on a plan's ability to sell itself to indi-



vidual consumers through catchy slogans and elaborate advertising campaigns rather than on its quality of service.

The administrative savings from these exclusive alliances we believe are grossly overestimated. In fact, there is the distinct possibility that the alliances with the thousands of new government employees needed to oversee and perhaps operate the alliances, will add a costly layer of bureaucracy to the system.

Under the President's program, as in the Cooper-Grandy bill, individual employees, rather than employers, have the ability to choose among all participating plans under the alliance. This feature will increase rather than decrease the administrative complexity and costs in the alliance. Health plans will incur additional costs to communicate directly with their enrollees each time there is a minor change in the plan, as for example the addition or deletion of participating physicians.

At the time of the annual enrollment, health alliances' offices will be worse than motor vehicle offices, and more like emergency rooms. Long lines while waiting for assistance.

Recent press reports indicate that the alliance will include 50,000 workers across the country to handle administrative duties. I believe that that number will drop if the service is slow. We suggest we build on our current system with a voluntary alliance containing two components; one, insurance reform inside and outside the alliance; and, two, a requirement that employers must offer plans to their employees.

In this system, all health plans, whether or not they participate in the alliance, would have to play by the same rules and insurance reforms and no plan could gain the system.

In addition to medical insurance coverage, most insurance carriers provide other products to employers, including group life, dental, and disability income insurance. To ensure competition, it is necessary to establish basic operational rules that prevent those firms closely linked to the health alliances from taking unfair advantage of their association in order to gain a better position with these other lines of coverage, in other words to prevent tie-in sales.

We believe there should be a wall between sale of these other employee benefit products and those that are provided as part of the basic coverage.

Finally, the President brings up the subject of personal responsibility in this plan. We would like to offer this addition, which we believe would instill more personal responsibility into the health care system. Employers should be given the option to structure a minimum benefits program through a high deductible plan. Coupled with a medical IRA, the funds in the account would be allowed to accumulate from year to year. Withdrawals would be permitted on a tax-free basis only for medical expenses, although unused funds could be used in retirement for long-term care and other retirement needs.

The medical IRA would belong to the individual and would be portable. But because individuals would be spending their own money for medical care, they would begin to take a more critical look at the way that money is being spent. As a result, patients will exercise greater control in choosing their own medical care. They will weigh their options and costs in a responsible way that

will lead to more prudent spending. A high deductible medical IRA is not a new idea but one that deserves serious consideration.

In summary, we support the efforts of the President and Congress to improve our country's health insurance system. As a company with a long history of providing excellent service and value to our customers, we want to be a part of the new system. We support mandatory coverage and voluntary health alliances. All we seek is the chance to compete. Thank you.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

Statement of John Gummere, Chairman and Chief Executive Officer  
of  
Phoenix Home Life Mutual Insurance Company  
Friday, November 5, 1993  
Subcommittee on Health  
Committee on Ways and Means

Mr. Chairman, members of the committee, thank you for inviting me to be with you today. My name is John Gummere. I am Chairman and Chief Executive Officer of Phoenix Home Life Mutual Insurance Company. Phoenix Home Life has a 142-year history of providing strong, dependable and innovative life, group health, group disability and investment products to a nationwide market.

Phoenix Home Life has been a provider of group insurance benefits for over 35 years, offering employee benefit coverages primarily to small employers. Eighty-five percent of our medical insurance customers are employers with fewer than 50 employees. The small business segment of the market is volatile, cyclical and has unique needs, but we know how to manage it. Our strategy is to work with these small businesses to provide the highest quality health care in a cost-effective way. We do this by integrating, into their employee benefits program, flexible managed care options such as preferred provider organizations and exclusive provider organizations. These managed care programs help to reduce the employer's costs while providing high quality care to their employees and their dependents.

We are not a large company. Our total annual group premium is about one-half billion dollars. We are small, efficient and skilled in dealing with small businesses. We have a good reputation in the marketplace. The 1992 California Insurance Department Complaint Study for the 50 largest life insurers gave us a perfect rating: no justified complaints. In Connecticut, according to the State Insurance Department, we ranked much better than most insurers, including the Gang of Five, which includes Cigna, Aetna, Met and Prudential, in terms of the fewest complaints on a proportionate basis. Our average small business customer has been with us for close to 10 years -- a long time, given the normal practice of churning within the group insurance marketplace. These facts, we believe, are a testament to our good value and excellent service.

Contrary to our critics' claims, we have not been profiteering on health insurance. In fact, for medical insurance alone during the past 20 years, we had a loss of 2.5% of premium. Our after-tax profits on group insurance were a modest +3.4%.

I am not here to defend the status quo. Phoenix Home Life strongly supports comprehensive health care reform and supports several elements of the President's proposal. Most importantly, we agree with the President that there needs to be a mandate that all Americans must have coverage. We prefer that the mandate be placed on the individual where, like car insurance, everyone must obtain and maintain a minimum amount of coverage. The alternative is a mandate on all employers to provide coverage to their employees, as the President proposed, and a mechanism for those who are unemployed to get covered. Without a mandate, the young and the healthy can game the system and buy coverage only when needed. Therefore, it is imperative that whatever reform package is enacted, everyone must be covered.

Our primary objection to the President's plan, and what I'd like to focus on here today, is the President's proposal for exclusive health alliances. While we support the concept of health alliances and believe that they should be part of whatever reform package is enacted, we have doubts about the design envisioned in the proposal. Our objection is based on three concerns:

- Exclusive alliances are unproven and untested;
- The plan will lead to a few carriers dominating the market; and
- The administrative complexity of the system will increase.

Proponents claim that exclusive health alliances will give small employers and individuals the market power of large employers, reduce insurance overhead costs and spread risks more fairly. The concept, however, is largely unproven.

Only a few states have enacted legislation to allow for the creation of purchasing alliances. In all instances, the alliances are voluntary, meaning that the employer has a choice to either purchase within the alliance or outside through an agent in the general market. Of the six states that have enacted legislation, the alliance is operational in only one state, California, where it started up in July of this year. We think that implementing exclusive health purchasing alliances on a national scale without adequate pilot experimentation is very risky.

Exclusive alliances will eventually result, within a few short years, in the domination of a few giant insurance companies and HMOs in the health care market. Such a concentration in the control of the market is not good news for consumers. The system will create lumbering giants that make money for their owners but who will turn out expensive, and increasingly poor quality, products for consumers. The market would lose the innovative and cost-efficient competitive pressure that the hundreds of small and mid-size insurers add. Instead, success within the alliance may depend more on a plan's ability to "sell" itself to individual consumers through media advertising than on the quality or efficiency of the care it delivers. A company's popularity in the marketplace may be more a function of its catchy slogans and ability to mass market than its quality of service.

The administrative savings from these exclusive alliances, we believe, are grossly overestimated. In fact, there is the distinct possibility that the alliances, with the thousands of new government employees needed to oversee and, perhaps, operate the alliances, will add a costly layer of bureaucracy to the system. The alliances will displace the many trained and skilled workers who currently handle the administrative functions for health insurance companies. For example, agents and brokers today help the employer to choose the best plan to meet needs, help explain coverage and enroll employees and their dependents. These functions will still need to be performed, but the agent/broker appears to be pushed aside by the alliance. People need the valuable services of agents and brokers.

Under the President's program, as in the Cooper-Grandy bill, individual employees, rather than employers, have the ability to choose among all participating plans under the alliance. This feature will increase rather than decrease the administrative complexity and costs in the alliance. Much time and effort will be required to answer individuals' questions about all the options available to them. Health plans will incur additional costs to communicate directly with their enrollees each time there is a minor change in the plan, such as the addition or deletion of participating physicians. At the time of the annual enrollment, health alliance offices will be worse than motor vehicle offices -- long lines while waiting for assistance.

In our experience alone, we receive an average of two calls per year per employee into our 800 number on issues not related to claims. Some of these calls concern census changes ... marriage, death, birth in the family. Other calls concern coverage and eligibility issues. Under the President's plan, alliances countrywide can expect up to a half billion calls a year from individual consumers with questions and requests. Recent press reports indicate that the alliances will hire 50,000 workers across the country to handle the administrative duties. I believe that number will grow if the service is slow.

Employers now play a key role in the current health care system. They help reduce the overall cost of administering benefits by coordinating communication between the plans and employees. Many employers have programs which encourage healthy lifestyles -- such as sponsoring weight loss and smoking cessation programs. With exclusive alliances, employers lose their role in the selection of plans for employees. They remove employers from the equation except as a check writer, a contributor towards the insurance costs of employees and their dependents. With almost two-thirds of Americans under age 65 receiving health insurance through employment-based coverage, it will be a mistake to remove employers from the picture. These positive contributions will be eliminated if the proposal takes the responsibility for arranging health coverage away from employers and gives it to the new, untested alliances.

In addition, exclusive alliances will be a costly administrative nightmare for employers. For example, in a small business with 10 employees, if each employee chooses a different plan, the employer could end up having 10 different employee health insurance premium deductions to administer. A more efficient alternative is to allow the employer to decide whether or not to participate in the new alliances and to encourage employers to offer a minimum number of health benefit plans to their employees.

We suggest that we build on our current employment-based system with a voluntary alliance containing two components: one, insurance reform inside and outside of the alliance and; two, a requirement that employers must offer plans to their employees. Under this system, all health plans, whether or not they participate in the alliance, would have to play by the same rules and insurance reforms, and no plan could game or cherry pick the system. A risk adjustment mechanism would still have to be devised to spread the cost of the higher risk individuals more evenly among the entire population, as well as to ensure that the social costs of the sick are spread among all employers, large and small, self-insured and not.

In addition to marketing medical insurance coverages, most insurance carriers provide other products to employers, including group term life, dental and disability income insurance. Because the public generally benefits from vigorous competition, it is important that the high level of competition that exists in today's marketplace for these other employee benefit products continues, despite the presence of the alliances. To ensure competition, it is necessary to establish basic operational rules to prevent those firms closely linked to the health alliances from taking unfair advantage of their association in order to gain a better position with these other lines of coverage. We believe that a number of restrictions should be set forth in the law to prohibit plans offered through the health alliances from any tie-ins or linkages of the purchase of any other insurance plan as a condition of securing health care coverage with the alliance. We believe that the health alliance should not, directly or indirectly, provide administrative services to any person or group in connection with the sale or administration of insurance products which go beyond the guaranteed benefit package. In other words, we believe that there should be a wall between the sale of these other employee benefit products with those that are provided as part of the basic coverage. This will prevent insurance carriers connected with the alliance from gaining an unfair advantage over competitors in the other group insurance markets.

Finally, the President discusses personal responsibility in his plan. We would like to offer this addition, which we believe would instill more personal responsibility into the health care system. Employers should be given the option to structure the minimum benefits program through a high deductible plan, coupled with a Medical IRA. The funds in the account would be allowed to accumulate from year to year. Withdrawals would be permitted on a tax-free basis only for medical expenses. Unused funds could be used in retirement for long-term care or other retirement needs. The Medical IRA would belong to the individual and would be portable, so a person could change jobs without losing benefits. But, because individuals would be spending their own money for medical care, they would begin to take a more critical look at the way that money is being spent. As a result, patients will have greater control in choosing their own medical care. They will weigh their options and costs in a responsible way that will lead to more prudent spending.

A high deductible, Medical IRA plan can work within the reform marketplace. Risk adjustors, which are used to guarantee a fair spread of risk, can be applied to these plans, as well as to all other plans in the market.

In summary, we support the efforts of the President and Congress to improve our country's health insurance system. As a company with a long history of providing excellent service and value to our customers, we want to be a part of the new health care system. We support mandatory coverage and voluntary health alliances. All we seek is the chance to compete with the alliances and the giant insurers and HMOs.

Chairman STARK. I guess it would be only fair to ask, I find a certain lack of balance in the panel. Is there anybody in the room who would like to testify in favor of the mandatory health alliance? The staff? The cameraman? Anybody else?

Mr. KATZ. It is unanimous.

Chairman STARK. The Chair, like Diogenes, has been looking for an advocate for the mandatory health alliance for some time and I am certainly not finding one in this group.

At this point, I would like to recognize the presence of my distinguished colleague from Connecticut, Mrs. Kennelly. She might like to say a few words or inquire of the panel.

Mrs. KENNELLY. Thank you, Mr. Chairman, very much. I thank the panel and wish that I was able to get here a little earlier to hear all of the panel's remarks. Fortunately, I was able to hear Mr. Gummere who is in charge of a business in my district, Phoenix.

Mr. Gummere, first of all, I have had, and I want to tell you, Mr. Chairman, that I have had discussions with Mr. Gummere about these nonvoluntary alliances, and he has had some ideas that I wonder if he could expand on for you and for me in the more formal occasion of this hearing.

What I am talking about is something that we have discussed, Mr. Gummere, the risk adjuster mechanism. It is something that probably would be necessary if the alliance was voluntary. And I know that you have had some technicians work on the possibility of a risk adjuster mechanism. Is it possible for you to expand on that idea?

Mr. GUMMERE. Mrs. Kennelly, I know there is a lot of work being done on this subject right now by the Society of Actuaries. I don't have any solution or certain knowledge of how that might be worked out at this particular point.

Mrs. KENNELLY. I think that highlights one of the situations that we are faced with with this whole proposal. What we are very aware is, Mr. Gummere, has certainly mentioned it in his testimony, is that we have all sizes of insurance companies. We have those you referred to as the giants that you are afraid will take over the whole system if the program continues as presented by the President, and then there are companies like yourself that you certainly couldn't call small. Your company is not a small company. It is a very good-sized company. Then across the country we have small companies.

And what I think we have to do is if in fact we are going to go the route of voluntary alliance assist, somehow come up with a plan that is workable that we could look at, that we can deal with, that we can say, well, if we don't have the mandatory alliance, we will have a voluntary alliance, but the voluntary alliance will have this, this, this, as criteria.

And so what I am suggesting is, we have just begun the first inning, more or less, now that we have a certain amount of the language in front of us that Mr. Clinton, our President, is presenting to us, but we can't just be against things. We have to have suggestions for alternate solutions.

And so what I would just say to you, and to the others on the panel, is that we have to remember that we represent people and

businesses, and that our business as Members of Congress is not to be in the business of putting people out of work.

We talk about mandatory alliances, and then we hear some of the testimony that we have heard today. We worry that before we even get going there are some companies that feel they could not exist under the present system.

Having said that, I still have to urge you, Mr. Montgomery, and others who are very active in the insurance world, and have been very, very good about providing insurance for these United States over these 200 years, that if you are very concerned, as you seem to be, over the mandatory alliance, you have to come forth with a suggestion of being able to have an alternate system that works.

And I would just urge you to continue to work on that.

Mr. Chairman, may I ask one more question?

Chairman STARK. Please.

Mrs. KENNELLY. Having listened to Mr. Gummere and the scenario about having individual type plans within a company whereas the company would provide a package of benefits, certainly not an extensive package of benefits but a package of benefits, and then have an IRA type of situation where dollars are set aside for the individual to call upon if they did get sick, I have two questions.

One, how does one establish the point where you have those benefits, and then what happens at that in-between period, say you have a gallbladder problem, is that or is that not in that basic package? How is that—we have the Clinton proposal in front of us, we have pages of what will be covered and what will not be covered. In the situation that I hear you describe, I don't know where that cutoff period is, where you in fact have that benefit, then there is a gap and then you go into the next step.

Can you expand on that a little bit?

Mr. GUMMERE. The way I would envision it is that there would be certain basic benefits such as prenatal care and birth expenses, which would be covered by the plan. But there would be a high deductible, and the premium saved for that high deductible as against the more traditional very low deductible plan would be a contribution to an IRA. Now it is very true that in the first year, there would be dollars available in the plan to cover the full deductible. But as savings accumulated over time, there would be money within the plan to take care of it.

Mrs. KENNELLY. So one would hope that one does not get sick in the first year?

Mr. GUMMERE. That is correct. I am not talking about everybody, because obviously we have to take care of those who are unable to take care of themselves, but for many people in the system, higher deductibles could be afforded in the current system, than the current insurance business makes available to them.

Mrs. KENNELLY. So if a gentleman walks out of your building and crosses Columbus Boulevard and gets hit by a car in the first year of this plan, what happens?

Mr. GUMMERE. He probably sues us for not having a clean sidewalk or something in the process. But seriously, Mrs. Kennelly, there would be a shortfall. But how much? A \$1,000? I don't know. \$500? I haven't, you know—it is certainly a lot less than three.

Mrs. KENNELLY. John, I know in this current atmosphere why we are going to have to do health care reform. With the exorbitant costs, it won't be a \$1,000.

Mr. GUMMERE. It will be less than three.

Mrs. KENNELLY. Let me take it to another avenue. This is an employer pattern. The employer sets up the plan. And the individual is part of that plan, working for, say, Phoenix.

Now, the IRA builds up, especially if you don't get sick or you don't use it.

Mrs. KENNELLY. And now are you saying that when that employee changes jobs, he takes that money out of the IRA and brings it with him to the new job?

Mr. GUMMERE. It stays in the same IRA or rolls into the new IRA with a new employer.

Mrs. KENNELLY. So that money is portable?

Mr. GUMMERE. Yes, yes.

Mr. KATZ. Let me just add something here. There are a variety of plans that have been put forward for these medical savings programs, some of which do take care of the first year situation which you identified. There are competing models of medical savings accounts just as there are of health alliances.

Mrs. KENNELLY. Is there any worry that there will be a habit developed by the people that are under this kind of plan not to go to the doctor, not to take the child to the doctor, to avoid going to the doctor so that the IRA will build up?

Ms. FOX. Yes, we at Blue Cross have lots of concerns about this type of approach. We just don't think that is the right way to go. We think you need to restructure the delivery system and encourage people to go into managed care.

Mr. KATZ. But, Mrs. Kennelly, I would add that we are not saying that medical savings accounts should be required for all citizens; we are talking about preserving consumer choice. Those consumers that wish to participate in the medical savings account situation, or whose employers make it available for them, should have the option of doing so. We don't believe that it is the end all and be all of a reform package. We need a lot more than just medical savings accounts. But it is a piece of what health underwriters support, which is to assure that every American has health care coverage.

Ms. JENCKES. Mrs. Kennelly, I am Linda Jenckes with the Health Insurance Association. I would like to just add we don't oppose medical IRAs. We think that they should have an opportunity to be tried and tested. The only problem that we basically foresee is that they really don't address the cost containment issue.

You cannot have medical IRAs absent other initiatives, whether it is antifraud measures, whether it is moving to administrative cost savings through an automated claims processing system, or whether it is encouraging more people to try managed care networks. Those features must move forward together with the IRA concept or we are still really going to have the health care plague in America that we all wish would go away and that is, rising health care costs.



Mrs. KENNELLY. One last question, Mr. Chairman. As the chairman has pointed out, there was no one in the room that volunteered to speak for mandatory alliances.

Chairman STARK. Nobody requested to testify.

Mrs. KENNELLY. No one. So obviously this is a part or a piece of the President's proposal that has presented a great deal of concern and frankly opposition. However, when we look at what we are doing and what we are trying to do in health care reform, let us keep in mind two things.

One, we are trying to get costs under control; and the other thing we are trying to do is get comprehensive health care, and that means everybody being covered. And I think that probably is the reason why the President's group came forth with a mandatory alliance, because when you have mandatory participation, everybody gets involved.

Let me assume a possible situation if you have a voluntary alliance. In some people's minds, Medicaid will be folded into the alliance under health care reform.

So you fold Medicaid beneficiaries into the health care reform proposal. Well, right there, you have got a pretty shaky risk pool. Now, if you have voluntary alliances and you or I have the ability not to want to be in a risk pool that looks like it could cause some expensive conditions down the road, you would find yourself a voluntary alliance that doesn't have the Medicaid population, or maybe contains a younger population.

How do we avoid this? This is why I go back to that list of adjusted mechanism that you and I once talked about, Mr. Gummere. Is there a possibility that we could have voluntary alliances that have the good risk, healthy people in it, and then we have the risk pool of the mandatory alliance where we are covering those that haven't been covered up until now in one alliance, and everybody who can run and get out of it go over to the other alliance. This would present a new problem. Everyone would have insurance, but we would have a two-tiered system.

Ms. JENCKES. Let me just make an observation about the necessary ingredients for health care reform which we believe are absolutely necessary. Number one, the ground rules have got to change for all insurers, regardless of who they are insuring, and that is, the right of any person to get coverage no matter how high your health risk, and to keep that coverage, no matter how many benefits you use in a given year. Insurance reform also has limits on preexisting conditions; and most importantly, it even has premium pricing limits. Once you have all insurers playing on this level playing field in terms of consumer protections, whether they go to a voluntary alliance or buy a policy on the open market, they are protected.

Now let me move to the concept of risk adjusters, and as I noted a little before you came in, we will be testifying specifically on that subject next Tuesday before the committee.

The Chairman is absolutely right. We have not done risk adjusters before, but we have our own actuarial task force, as does the American Society of Actuaries who are looking at it. The key issue is whether it is individually based. In other words, we need to determine whether you look at that risk adjustment totally on the

basis of individuals, or whether it is on employer groups, for which we have data and statistics today. So what we are going to come up with is several options to see if they are workable.

However, our recommendation in the interim, until we can move to comprehensive, universal coverage for everyone, is to use the reinsurance mechanism that many of the States have adopted today. If one insurer has a disproportionate number of risks when they take on the people who have been either previously uninsured or perhaps underinsured and don't know how high the risk, the reinsurance pool spreads the cost of those risks among all insurers at the end of the year again so no one company is unduly affected.

Ms. FOX. Mrs. Kennelly, at Blue Cross and Blue Shield, the way we think you deal with this risk selection problem is for the voluntary alliances, we think that first you tell health plans that they have to take all comers and they have to community-rate their coverage, so they charge the same rate to all comers.

If you have a voluntary health alliance, we think the requirement should be that you charge the same rate, whether or not you are in the voluntary health alliance or outside the voluntary health alliance. We think that addresses the problem people have raised that if you have voluntary competing health alliances, that you will have risk selection, just like you had mentioned. We think it would eliminate that problem by saying health plans must offer everybody the same price in or outside of the health—the voluntary health alliance.

Then what is the purpose of the voluntary health alliance you might be thinking. The answer to that is we think you should use the voluntary health alliance as a vehicle for offering small employers individual choice. So small employers could join these voluntary health alliances and would give their employees individual choice of a number of health plans and it would start looking at individual choice. So that is how we would approach the problem.

Mr. CUNNINGHAM. Mrs. Kennelly, I am Sam Cunningham. I am President of the Association of Health Insurance Agents. We have dealt with this issue continually. We feel that with an employer mandate, plus a reformed insurance market, and an expansion of the social safety net, you get fully universal coverage. The mandatory alliances are not necessary.

We have done a paper, working with HIAA, just a cursory review of an open health alliance risk adjuster, that we would be more than happy to share with you. But what we are saying is, if you level out the playing field and you require coverage, then, in essence, the market will take care of itself. That is our first belief. If we need a fallback position to a risk adjuster, we are already giving that some research, Mrs. Kennelly.

Mr. KATZ. Mrs. Kennelly, there is an assumption you made which I think needs to be addressed, and that is that the Medicaid individuals will all wind up in the State alliance. Health Underwriters, through its Real Choice proposal, would give in essence vouchers to individuals so that we don't ghetto-ize the Medicaid population into health alliances. They would be free to purchase plans from any carrier in the marketplace through health alliances where they exist, and directly with carriers.

Chairman STARK. You have a voucher at the rate of the highest cost plan in the alliance or the lowest?

Mr. KATZ. The way we do it is we would have the establishment of an essential benefit package and it would be set at that for within a—

Chairman STARK. So they wouldn't be able to buy into any plan, but just a certain plan.

Mr. KATZ. Correct. Correct. And by the way, there are advocates of exclusive health alliances and they tend to be the State agencies that operate the voluntary health alliances. They would like to eliminate competition.

Mrs. KENNELLY. I would just like to end by saying to you, and Linda, what you said makes me feel better about this. Because you know, I have a feeling that by having mandatory alliances, we could put an awful lot of people out of business, and I think I am looking at some people who represent those people.

However, my experience, taking another area of health care reform, is I have some trouble with premium caps. I think that the history of our country has shown that cost controls have not worked.

And yet, no matter who I sit down with to discuss my concerns about premium caps and the possibility that they will be too tight or they will cause rationing, I am told: Fine, you don't want to have premium caps, at the moment that is one of our number one ways for cost control; you come back and show us another way to control costs. And I think that is what we are going to see more and more. We see it on the committee in every fashion.

If you want to do something, have you to pay for it.

But I would really caution you that to be taken seriously that you are going to have to come up with an alternative that passes the test that ensures that people do get universal health care. If you can do it, I think you are going to have a lot of people very willing to listen. But if it doesn't have the criteria of taking the test of workability, I think you are going to find yourselves in a situation that you are in today.

Ms. JENCKES. Mrs. Kennelly, can I just add one thing? We agree with you on some of the potential problems with the premium cap, as even did the Congressional Budget Office in the report they gave to Chairman Stark. We wish there was one single magic bullet when it comes to cost containment but there isn't.

Just as we know we would like to have universal coverage tomorrow, we can't because it has got to be phased in. So I don't know how we respond to some of the critics on cost containment issues when they feel that premium caps are the only way to go. The point is, I wish we could somehow evaluate and include the potential cost savings of things that are underway today, which have been encouraged by the Congress, and which will continue, such as the antifraud activities. Mr. Stark, you also have the physician self-referral piece of legislation. There is also the administrative cost savings initiative, moving to a paperless system of paying claims, and the fact that many managed care networks actually save dollars. So I wish we could somehow collectively figure out how we, if in fact we are going to have universal coverage, whether it is the

year 1997 or 1998, can also assess the impact of these other cost savings measures along the way as well.

Chairman STARK. I know you are not old enough, but do you recall how long it took us to phase in Medicare?

Ms. JENCKES. I did start in 1969. The law was passed in 1965. I mean a couple of years.

Chairman STARK. It took us 30 seconds to phase in Medicare, which was universal coverage for everybody over 65. We had no trouble then. Why do you anticipate we would have any trouble now?

Ms. JENCKES. Well, Mr. Chairman, I mean we are talking about a population then, if my memory serves me right, but I will submit this for the record, that was maybe 15, 16 million people.

[The following was subsequently received:]

#### CURRENT MEDICARE FIGURES

Medicare was enacted July 30, 1965, and began operation July 1, 1966 (p. 50) with about 19.1 million enrollees (p. 261, table 7.B4).

Payments from the trust funds were made beginning July 1, 1966 (p. 255, table 7.A1). In 1990, 30,464,000 people age 65+ were enrolled for Part A, 29,685,000 for Part B. About 540,000 of the Part B enrollees did Not have Part A, so the either/or total is closer to 31 million.

Page citations are to: U.S. DHHS, Social Security Administration, Social Security Bulletin, Annual Statistical supplement, 1991 (SSA Publication No. 13-11700), Washington, DC: U.S. Government Printing Office.

Chairman STARK. No ma'am.

Ms. JENCKES. In 1965?

Chairman STARK. No, it hasn't grown that many. It doesn't make any difference.

Ms. JENCKES. Whether it is 10 or 20 million, you are talking that versus 250 million, and you are also talking, if we are in fact discussing the President's proposal, a totally new restructured program.

Chairman STARK. That is exactly what Medicare was.

Ms. JENCKES. It was patterned after the Blue Cross and Blue Shield model, actually.

Chairman STARK. No, ma'am; no, come on. It was a new program in its entirety, and it may be difficult and it may be politically unpopular, it may be expensive, but there is no reason on God's green Earth, other than cost, that it has to be phased in. We can just do it. We probably—

Ms. JENCKES. If we can find the dollars, and I hope the projections are better on universal coverage than they were on the Medicare program.

Chairman STARK. Don't make those broad statements about what we can do and can't do. There is no reason that the President's requirement for universal coverage, not access which is another issue, can't be done immediately. And there is no reason that we could not have universal access immediately and phase in the benefits, for example.

Ms. JENCKES. We are all for it, if it can be done.

Mrs. KENNELLY. Mr. Chairman, one last question of Mr. Gummere. If, in fact, the employee doesn't change jobs, he is fired, what happens to his IRA?

Mr. GUMMERE. If the employee is fired?

Mrs. KENNELLY. Is fired.

Mr. GUMMERE. He still has his IRA.

Mrs. KENNELLY. He still can go to you and collect on his IRA and take it with him?

Mr. GUMMERE. Yes.

Mrs. KENNELLY. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Ms. Fox, you have some trouble with a single standard benefit package, and I think you were unique among the group. I guess there is a couple of questions.

If that benefit package were minimum rather than more generous as it is now, would you have the same concerns, and I gather you would be comfortable with perhaps three packages, but maybe you could elaborate. What is wrong with some kind after Federal minimum? Why do we need more than one standard?

Ms. FOX. I think you are exactly right. It is that it is a fairly comprehensive package and it is really the affordability issue that we are raising here.

Chairman STARK. So if it were a minimum benefit package, would you have no problem? OK.

Ms. FOX. Exactly.

Chairman STARK. That was a unique sort of issue that stood out.

I am interested in the agents' praises of our Governors' HIPC which is broadcast as a way to solve the problems of California taking the lead in the uninsured, and the issue of 79 percent of the business sold through independent agents. I suspect, Mr. Katz, and Mr. Cunningham, you both have seen the application form?

Mr. KATZ. Yes.

Mr. CUNNINGHAM. Yes, we have, and we think it probably really justifies the use of an agent.

Chairman STARK. Because it says on the form, there is a little box that says, did you talk to an agent in regard to this? And if so, you put the name in the box. And then the agent gets \$4 a month; right?

Mr. KATZ. It is a little more involved than that.

Chairman STARK. A heck of a lot more.

Mr. KATZ. They also had to explain it to the employer and help with the enrollment.

Chairman STARK. There is no place that that is particularly certified. I understand that there are several businesses which pre-stamped those applications with enterprising agents' names and for these valued—somebody calls them valued agents using their expertise, and they pick up a couple hundred clients at \$4 a month forget their name stamped on applications that are handed out like Ed McMahon's chance to win \$100 million, and I would just note for the record that that hardly seems like a major act of complication.

Further, that out of these 20,000 who signed up in that plan, it is interesting to note that only 3,000 were uninsured. The balance were people who had their own insurance and switched plans.

Now, one wouldn't begin to suspect that they only switched plans because the agent would get a new commission for moving them out of another plan into this plan whose savings came entirely from lower benefits. But the interesting fact is that at that rate, it will only take California 75 years to cover the uninsured.

And I hardly think that that is what the President had in mind when he suggested that we would have universal coverage. So that while I am generally proud of the fine wine that is made in the State of California, I sometimes rather suspect that some of these programs may not be the panacea, except for agent's annuities, that they seem to be the only ones who may benefit at any great amount in that plan.

Mr. KATZ. Mr. Stark, if I may respond to elements of that.

Chairman STARK. Sure.

Mr. KATZ. First off, although I would never want to take credit away from Governor Wilson, the driving force behind the passage of H.B. 7962 was Assemblyman Burt Morgollen, who happened to be my assemblyman at the time so I happen to feel somewhat incumbent to give him credit for that.

Second, I worked very closely, both in the passage of that bill and the creation of the health insurance plan of California with the State agency that oversees it, and I assure you that if you have a list of those cases or know the agent who merely stamped the application with their name on it and did not meet the three point requirements that are placed there in order to obtain compensation for the sales and service you have done, that the health alliance will remove the agent fees from that particular case. If those employers were taken advantage of, the State will make sure that—

Chairman STARK. Or employees.

Mr. KATZ. Or the employees. Well, it is the employer who signs the application, actually.

Chairman STARK. How about the equitable agents? Have you guys kicked them out yet?

Mr. KATZ. Equitable is not a major player.

Chairman STARK. Mr. Cunningham.

Mr. CUNNINGHAM. Mr. Chairman, I would like to address—

Chairman STARK. Are those agents still members of your organization?

Mr. CUNNINGHAM. The equitable agents? They haven't been specifically excluded, so it is a situation where I am not aware of maybe something you are aware of. But I wanted to address what the agents do basically with regard to the HIPC when they sign people up.

They have to make sure that they get the proposal over the proposal, that they enroll the people, and that, by the way, this is an annual decision the employer has to make whether or not to continue with the agent or not. So I think it is as close to basic as it can get.

It is like Alan said. If these people are doing this, then we would very much like to know about it, because we can get the proper State agency to take care of it.

Mr. KATZ. And Mr. Stark, I hope you won't place too much of a burden on the voluntary health alliance California has. When we passed A.B. 1672, its purpose was to create a fair and stable marketplace to prevent some of the cherry picking and other abuses that may have taken place by the industry. It was perceived and passed with the recognition that it was only the first step toward a series of reforms.

It does not, for instance, include an individual mandate as Health Underwriter's Real Choice would do. The fact that 20 percent of the uninsured—of the cases taken in by the health alliance are from previously uninsured groups is a very welcome result of that. I would also say that we have done a study that seems to show that private carriers who are playing by the same rules on a level playing field with the health alliance are also reporting in a small group market that 20 percent of their business is coming from previously uninsured groups. But it is not intended to be the answer to universal coverage.

Chairman STARK. Does your organization, Mr. Katz, support a mandate on the individual? Is that what I heard you say?

Chairman STARK. Correct. Or that they must have insurance?

Mr. KATZ. Correct. And as I mentioned in earlier testimony, a voucher is provided for the low income.

Chairman STARK. And pay for it. In other words, basically you are mandating—

Mr. KATZ. Correct. We would—

Chairman STARK. Do you object to a mandate on the procedures?

Mr. KATZ. Health Underwriters rejected that in favor of the individual.

Chairman STARK. All right. I am going to ask each person in turn. Mr. Cunningham, does your organization support either—

Mr. CUNNINGHAM. We support an employer mandate.

Chairman STARK. Employer.

Mr. CUNNINGHAM. The reason that we support the employer/employee partnership is basically because we feel—

Chairman STARK. I am just trying to find out where you guys are. Alissa, where is Blue Cross on the mandate issue?

Ms. FOX. We support both, the employer and the employee mandate.

Chairman STARK. Either/or, or—

Ms. FOX. No. I mean together. The employee must accept the coverage with subsidies.

Chairman STARK. Who pays?

Ms. FOX. Eighty percent employer, 20 percent employee.

Chairman STARK. You are in the 80/20 group. Linda.

Ms. JENCKES. We are actually both, the individual and the employer. We haven't come up with a set amount as to whether it is 80/20 or what.

Chairman STARK. But you feel that both should contribute.

Ms. JENCKES. Absolutely. On a sliding scale basis for those that are right above the poverty level, the working poor. Mr.—

Mr. SADICK. The coalition is an eclectic bunch and some support mandates and some don't.

Chairman STARK. So you have no position on that. Who have I missed?

Mr. Gummere, you are speaking for your company?

Mr. GUMMERE. I prefer the employee mandate.

Chairman STARK. And would you object to the employer mandate? Would you support it?

Mr. GUMMERE. The purpose of a mandate in the first place is to eliminate gaming; and the best solution, therefore, is the employee mandate.

Chairman STARK. OK. I know of no other way, quite frankly, to get—if we really mean universal coverage, I guess we mean it. I don't care what you call it, a rule, a law, a mandate, we have to say everybody has to have health insurance. Now, I presume you can—then the question is, how much do employers have to contribute or how much do individuals.

But I can assume, then, with the exception of Mr. Sadick, whose group hasn't taken a position—that a mandate of one form or the other with you would agree that on individuals there should be a mandate and that that implies some responsibility for paying for it if you can afford it, and that some of you feel that also the employer—not all of you, but about half of you feel that the employer should have a mandated responsibility.

The others would either object to that—because really, there isn't a heck of a lot to ask you guys about the alliance, because you are all against them. So I want to see are there any of you who do not support open enrollment and basically no underwriting?

Ms. JENCKES. Well, maybe I need to make a slight modification on that. We are for modified community rating, and I don't know, Mr. Chairman, if you want to refer to that as traditionally medical underwriting. We are not for medical writing to exclude any one from coverage.

However, we feel that you should look at the age, sex, occupation and location of the group to put a fair price on the product. Let me give you a brief example.

The State of New York just put into effect pure, flat, community rating for small businesses. If you are a 30-year-old male your rates just went up 170 percent. That is according to New York State's insurance department figures. We don't think that is fair.

Chairman STARK. Well, OK. Once again, once you start unraveling something like that, particularly in the absence of risk adjustment, there is no end to it. In other words, if we knew, and we don't, how to adjust for risk, you might be able to take those elements into account, but we don't. And that is just a problem.

Once you say that I don't even think you can do age, it is too easy through marketing to select on a basis of age. It is too easy for Mr. Katz and Mr. Cunningham's associates, who are experts, to design both advertising and a whole host of issues that will tend to pick up one age group or another; and that is a form of risk selection.

And while I would agree with Linda, your group's idea that you may have to phase in to a complete community rate, I suspect that your organization could live with that, and by how long, I would say three, they might say five, but somebody else might say four.

But the only way I could see it without getting into another 1,300 page booklet on how you could rate or not rate, of going to community rating it seems to me to be the only equitable answer. But maybe somebody will come up with something better.

You all agree on, depending on where it is that we could deal with a federally-defined benefit package?

Mr. KATZ. If it is a floor and not the only "one size fits all" package that all Americans would have to have.

Chairman STARK. OK. Anybody—I am just trying—as you know, that is the Chair's idea of where we may end up. I think, without



trying to be disloyal to the President's package, I would make this statement and see if you agree. All benefit packages are the same, save the co-pays, the deductibles and the premiums.

For the most part they all take care of your appendix and other known organs in your body. It is a question of how much you pay up-front in the form of a premium or what you pay in co-pay and deductibles and therefore they are pretty linearly adjustable by those payments. I just think we are—the package is quite expensive as it is designed, and we are not going to have the money.

So if we get the package lower, that leads to you all, a supplemental market that gets bigger. The lower the benefit package, the more opportunity there is, the more room there is for unions to bargain with employers, I suppose. But at any rate, so far today we are all on target on a benefit package; no preexisting condition exclusions, that is OK with everybody? All right.

I am just doing fine here. Now let me sell you my plan.

Ms. JENCKES. Excuse me. Mr. Chairman, would you please introduce that bill?

Chairman STARK. Let me see if we can get some disagreement in the group. Well, let me ask this one more question, and I am not really being facetious here. But Linda, if we have all of this and we do it right, then I have a little problem in finding out exactly what there is left for insurance companies to compete with. Think about this a minute.

Only the big companies arguably will have the capital to operate a managed care plan, and probably only companies the size of the blues will have the resources to get into being an intermediary in that format. If the smaller companies don't have the market clout to negotiate rates and fees, or operate a big—and it is my understanding, I think I remember somewhere along the line that you need about 10,000 people even to operate an HMO—and maybe that figure is off, but I have a hunch it is that order of magnitude. That is a lot of folks in one community for a middle-sized insurance company. What is left to compete with?

Ms. JENCKES. Mr. Chairman, fortunately, we think there is going to be room for every sized carrier, because there are some larger companies that just really prefer not to go to a rural area, or let's just use California as an example. They want to be in San Diego, they want to be in L.A., they want to be in your district of Oakland. But who is going to go to India, California? There are many small and medium-sized companies that have targeted these areas.

In addition to which, there is much consolidation that is happening in the insurance industry today. For example, many of our medium and small-sized companies that did not have the financial capabilities in the past to establish networks are in fact renting networks from larger carriers who have already penetrated a given area. So we are seeing all kinds of accommodation happening again, even absent legislation.

Also, there are many companies that do not underwrite traditionally either group or individual health insurance, but they are, as you suggested, perhaps Medicare supplemental underwriters or they have decided to specialize in long term care. The bottom line is, the most efficient and quality conscious companies are going to continue to survive.

Chairman STARK. All right. I have no quarrel with that. I just find that if we begin to standardize this package, then there isn't a whole lot of product differentiation.

I understand in the supplemental market which is what I have always felt will be the evolution as you get—I mean it seems to me after a few go-rounds of bidding with an alliance if that is what we have, there isn't a lot of reason for the smaller groups that didn't make the bid to become an accountable plan to stick around, and after 3 or 4 years they aren't going to have their hospitals and their doctors to bid the next time.

So invariably you get further up the pyramid and get bigger group, ever smaller number of ever larger groups servicing an area. What does this leave for your smaller companies?

It begins to leave the supplemental plan with very little long term and limited risk, which I don't think is such a bad market, but it is not my business to decide what ought to be good for them and what not.

But let me then just suggest this: Maybe I won't agree to this. If we have a voluntary system, which means in effect that any insurance company can bid in, but we must have coverage and access, and we are going to have some areas—I think, Linda, you hit on it. I know we will have some areas where a broad range of insurance options will not be available for a variety of reasons. So I have said that doesn't trouble me.

I am concerned about what the government will do if a State for some reason doesn't provide, like Hawaii or California. And so I have said, why not allow whatever this new Medicare type plan may be that the government will have to have as a—I think as a safety net program, why not let us compete right alongside, as long as we don't subsidize it?

If we become the plan of last resort, let's say that Medicare becomes the minimum benefit, which is probably closer to what we will have, and in South Dakota you can't cover the few Medicaid or an Indian tribe, what is wrong with their buying Medicare? Anybody object to that?

Ms. FOX. Mr. Chairman, we would differ with you on that. We think Medicare—and we have had a lot of experience with Medicare, as you know—just doesn't provide the right incentives for providers.

Chairman STARK. No, no, no. I am saying nobody else wants these people. I am taking the great unwashed and the undesirables and the tough ones where you don't want—I am not saying anybody has to, I am just saying they have a choice. Do you object to that?

Ms. FOX. We are concerned that it would perpetuate the fee-for-service type system.

Chairman STARK. Well, you know, there are a lot of people who want that.

Ms. FOX. I understand that. But we are concerned that the government operating this program, that it would perpetuate the fee-for-service type—

Chairman STARK. You guys operate it in practically every State. Don't give me the government. Come on. You don't object to Mr. Gummere coming in and competing against you, do you?

Ms. FOX. No, sir.

Chairman STARK. Well, why me?

Ms. FOX. It is basically what do you want the new system to look like, and we think the way——

Chairman STARK. Which new system? No, no. I am just saying, if you accept the fact that there may be some areas—and we have had testimony in ward 7 and 8 here in the District of Columbia, we just don't have anybody who will go in there to take off the 150,000 people, most of whom are Medicaid or poor.

Now, if, in fact, nobody wants to go in, Mr. Gummere doesn't have an agent that wants to go down there and knock on doors at night and Blue Cross can't——

Ms. FOX. We do serve everybody in the District and have——

Chairman STARK. If they can afford you.

Ms. FOX. Yes, sir. And we think that when you have financing, everybody will be able to afford the program.

Chairman STARK. Well, I am just saying, then you wouldn't mind if we compete.

Ms. FOX. We think we would be there and there would be other competition.

Chairman STARK. Why can't we compete with you? Then we don't have to regulate you. I mean we have some kind of a base plan. I will tell you this.

There are some States, you may not believe this, there are some States in which we couldn't win. There are some States that are so low-cost, we have to hit—we do community rate for the most part. We can't compete in some cases. In Manhattan we can, in Los Angeles, we would be the low cost guy on the block. I am not so sure in some States we would. You still object?

Ms. FOX. We have some concerns about how it would work. Maybe we need to think it through more, but it strikes me that it is unclear what the incentives would be——

Chairman STARK. What incentives? We have been talking about competition all day. What is wrong with me? Are you afraid of us?

Ms. FOX. We have concerns about how government-run system competing with the private sector, how that would work, and we would be happy to look at it further.

Chairman STARK. What would your concerns be?

Ms. FOX. Just what I have outlined.

Chairman STARK. That we would steal the money? I mean that is reasonable. We find those among us who do that, and we put them in jail.

Ms. FOX. We would be happy to look at it further, Mr. Chairman, and get back to you.

Ms. JENCKES. I am going to make a stab at this. That is off the record.

Mrs. KENNELLY. It is on the record.

Ms. JENCKES. If you actually eliminated the cost shift, which last year was \$22 billion, and you, as the government, did in fact pay your fair share, we would probably look at the notion of having—this is not an official association position, of having an opportunity to compete with government. If all barriers were removed, maybe there is something we could work out.

Chairman STARK. You just touched on it right there. As a practical matter, somebody asked me earlier, you know, did I insist on cost control on the private side and I said no, I don't care. You guys want to fight cost controls, be my guest. I think it would be very irresponsible of me to give in, but you all recognize there is cost-shifting.

I recognize it, it happens. Now, if, in fact, we stop it, and if you look at the President's plan and Medicare, they are very similar in their cost control. Almost—and at the bottom line, identical. Medicare has premium caps now. If you are a risk plan, then we determine how much you are going to get. If we don't have any and we have pretty tough hurdles to get over to get in, but we have a premium cap, right?

We also set fee-for-service rates for hospitals and doctors, exactly what the President is suggesting on his side. Now, if you have that, you can stop the cost shifting. If you don't have it, and it is no never mind to me, but I predict that both the insurance industry and your larger clients would be in here in a New York minute begging for cost control, because as we get pressure, as we are going to get next week to keep lowering the Federal budget, we can ratchet it down on Medicare and Medicaid.

It is going to show right up in the hospitals and doctors in your clients unless, as you say, we have controls on both sides of that equation. If we did that, it just seems to me that there will always be a need—the Veterans' Administration may not like to hear this, but there are veterans, CHAMPUS, there are government employees, there will be a need for some government plan. All I am saying is if you want to open this up to choice and not have to build all of these structures, we could do away with this alliance business in a minute and just say any neighborhood, it doesn't have to be any State, where they can't get insurance or the community doesn't think that they can buy Medicaid coverage from an HMO cheap enough, here is the government plan, and it is there, it is open enrollment, and we will have hellish adverse selection for a year or two until we get you guys into the box on your selection.

But recognizing that, I still say, that almost solves the problem. You mandate everybody must purchase insurance.

You can do that on the one hand, but you still haven't made every insurance company make it available. Where they don't, we do. And you guys can then decide where you choose to market, and we would not go out and compete against you, but you then wouldn't need these huge government hammers that say if a State doesn't pass something, we are going to go in and tax every employer in the State and run it from Washington.

We will just say until the States are able to have a plan in place, the safety net is this program. And then it is seamless. If we take on the early retirees, you have to make a case that if Medicare is good for you at 65, why is it bad for you at 62? I mean if we have to buy out big corporations and their early retirees, why not put them in Medicare early? Why dance all around the issue?

Now, chew that one apart, Mr. Katz. Could you live with that?

Mr. KATZ. Well, you raised some very exciting possibilities. The danger is, and I think why your proposal might meet with some objection, is the crucial element is that there must be a level playing

field, that the Federal program does not tilt the playing field in its favor. The experience we have had is that when the State changes from being a regulator, in essence being an umpire and steps up to the plate, they are very rarely called out on strikes. They tend to call the balls and strikes in their favor. So there is the distrust element, if you will, that is very real.

Chairman STARK. I understand that.

Mr. KATZ. As to whether—once the Federal Government becomes a competitor and the regulator, whether it will remain a level playing field. But if there was a proposal in writing, we would be happy to work with you in developing—

Chairman STARK. Well, what I have is a hunch, arguably we don't have the overhead that your companies do, that Mr. Gummere does, but we would probably get jammed with some adverse selection. I just—I suppose that—

Mr. KATZ. As an example, taking the California plan, the health alliance there, it was feared that that would be the dumping ground for bad risks. Now, it is way too early, it has only had an effective date since July. But based on all of the information that we have of these 20,000 enrollees thus far, their age spread, which is a good indicator of risk, is as good or better than competing plans in the market. Now, interestingly, the health alliance is not the least expensive plan in the market. You commented that the Federal Government would be the most competitive plan in L.A. I am not sure about that, based on the experience we have had.

Chairman STARK. The only reason I say that is because I know the physician and the hospital rates in L.A. are substantially higher than ours, but in some areas of the country actually they are not.

Mr. KATZ. The key for us and for our clients is that there be a competitive marketplace with a level playing field. I happen to believe—you were talking earlier about how it might lead to just large carriers and the boutique firms would fade away. I don't think that would be the case.

Chairman STARK. Let me ask you this: Do you supplement medigap?

Mr. KATZ. My company does, yes.

Chairman STARK. You don't get any complaints from your clients that Medicare is no good.

Mr. KATZ. When we have problems, they do. Well, they call their Congressman.

Chairman STARK. Is it Travellers in southern California? Who is the intermediary?

Ms. JENCKES. I understand that Blue Cross and Aetna are part A intermediaries in southern California and Transamerica Occidental is the part B carrier.

Chairman STARK. Mr. Sadick, how does that strike you?

Mr. SADICK. Well, like I said before, Mr. Chairman, we really haven't taken specific insurance positions.

Chairman STARK. Take that one back to your group.

Mr. SADICK. I will, because we have insurance companies and agents among retailers, the Alabama Retailers Association and the Western Growers, too; so there is a very wide cut there.

Chairman STARK. Mr. Cunningham.

Mr. CUNNINGHAM. Our group would have the same concern that Alan's group would have, and that is it would come out, start pristine, start fair, start level playing field and everything else, but it would tilt and that would be our main concern, is that if you have the perfect environment, where you have universal access, why would you need the Federal Government to step in would be more our question.

Chairman STARK. Well, we needed them for Medicare, right? Nobody wanted to insure seniors. It is a loser.

Mr. CUNNINGHAM. OK.

Chairman STARK. OK. And we have the same problem in many communities throughout the country, some large, some small, whether it is rural and it is access, or whether it is inner city and it is trauma care or drug or AIDS, I mean there are markets that are excluded for better or for worse.

Now, I don't suggest for a minute that if you didn't hold the cost of the providers down—Linda got at that—so that if you let the hospital costs and the doctor's costs go up on the private side, look, I am not trying to kid you, my plan would lead in a short order to single-payer, because your costs would go up, my costs wouldn't because I can control my providers cost through the Medicare.

I am not trying to kid you. This would, this one could, unless you are principals, unless you are companies who are very tough in negotiating low rates or running managed care operations. Medicare would not be running managed care HMOs. That would still be up to the private sector.

And so as the insurance industry was running those, they wouldn't necessarily be competing. It is a way to move more quickly, as I suggested to Linda before, to providing coverage. If it isn't mandatory, it is a matter of indifference and how quickly the States are forced to add.

Mr. CUNNINGHAM. Our feeling is if you add more carriers to the market, it doesn't solve the problem. We have enough carriers out there in enough regions. The thing is the people who are going to buy have probably bought. You know, many of our employers who we already insure are already paying for the people who don't buy.

Chairman STARK. I will take it a step further. Let me just finish and make it horrendous for you. How would I enforce it?

What I would basically do, rather than create another income tax form the way the President does for the alliances, is I would—let's say that it would cost \$1,500 a year for a single, under-65 adult to buy Medicare with a \$3,000 out-of-pocket cap. That is about where we would come out.

That is with all of the other company-pays and deductibles there. You put that on your tax return. You just print it right across the top. You owe us \$1,500. How do you get out of that? You attach to your 1040, just like your W-2, or a certificate that you as an agent would provide to your client that says, your client has an insurance policy that provides these minimum benefits, that therefore, when you fill out your return, you just take a credit of \$1,500, if there is some other way, I don't care how, you have a plan.

Mr. CUNNINGHAM. So it is pay-or-play basically is what you are saying.

Chairman STARK. On the individual. And if you are very poor, either you don't file a return, so we don't collect from you, or if you are in that gray area where we want to subsidize people according to your income, we will charge you a certain amount. Or if you are—if you work part-time and the employer is required to kick in so much an hour, let's say that we get something like that, it comes back—and it is simpler. The employer, Zoe Baird—excuse me. That is your constituent.

A person who is a household employee pays like they should now, 50 cents an hour. They work 1 hour, they work 10 hours. And the person has a credit slip in a sense the same as they would have a statement of their insurance, so that we don't have any new bureaucracy to collect the money, and we would just go on through.

Mr. KATZ. Mr. Stark, we would argue that it would be important for that credit also be portable to that individual and be able to be applied to any plan that is out on the market.

Chairman STARK. Well, in effect, it is, Mr. Katz. What it says is that this is how you enforce the individual mandate.

But I say to you, you must have insurance, Mr. Katz. OK. How do I do that? Send somebody around to your house and knock on the door? No. On your tax blank, it is printed in, \$1,500, you owe us that.

Now, if you in fact have insurance that hits the minimum standard, you don't have to show me you pay the—maybe you got it for a thousand bucks, I don't care, you get credit for the \$1,500. Do you see what I am saying? So as close as we can come to saying—

Mr. KATZ. As long as it is a refundable tax credit so that if I don't owe taxes, I still have \$1,500 that I can apply toward whatever plan in the market is available. That allows—

Chairman STARK. Well, you don't go below zero. I mean it would be a separate item and you could not offset this with other losses. I mean this would be just a way of collecting.

So in effect, it would be as close to a voucher as I think you are going to see us get. But it is a way to enforce the individual mandate. I mean people say we want an individual mandate. I say fine. Do you want us all to have a tattoo on our forehead when we get insurance?

So an easy way, no newer bureaucracy, is you show it on your tax form or you have to pay a penalty. And then for those people who can't, they are in Medicare. So they go to the hospital. So no emergency room, basically, as anybody shows up that doesn't have insurance.

Mr. KATZ. Again, I think our major difference with your proposal is that if you are low income, you are in the Medicaid population that you not be required to buy a particular plan, that this voucher that you have described be portable within the market.

Chairman STARK. That is right. I will go back and just say it over again. Even if you are poor. Now, if you are really poor, you don't file a return, you basically don't pay. We might have to make poor people file a return to keep track of insurance. But one presumes that at some level you don't file a return, you have got it.

I mean that, in effect—if you were going to fold Medicaid into this plan, that is how you qualify. You don't have to fill out a sepa-

rate form to qualify for Medicaid. Read the President's bill in terms of what you have to do, not even for poor.

If you work in one of these small companies where you are one of the under 75 employees, basically you have to fill out a form that amounts to a second income tax form, and then your employer has to collect it, getting not only your salary information, but whatever other income information you have, add it all up; and I mean you want to talk about paperwork to qualify this plan to get the subsidy, I mean to tell you it gets pretty horrendous.

I am saying, you can put my plan aside of offering Medicare, collecting and accounting for this through the tax system. Now, that is a danger, is that my opponents—none of you would oppose me, but my opponents will call that a tax, just as sure—but they are also going to call it a mandated employer tax.

So I figure what the hell, I am in for a dime or a dollar. I mean Rush Limbaugh is already calling this an extra tax, and he isn't going to stop. So I figure all right, if that is what it is, let's go ahead and face it and find a way that I can get all of you to endorse it.

Mrs. Kennelly.

Mrs. KENNELLY. I just was puzzled by something in Mr. Gummere's statement. Mr. Gummere, you say that at Phoenix Home Life, 80 percent of your insurance customers are employees of small companies under 50. And yet further on in your statement you say that you are in favor of employee mandates, the individual having the mandate, and yet 85 percent of your business is employer? It just puzzles me.

Mr. GUMMERE. Well, that is correct, for the reason that I said. I feel that the employee should be mandated, because that is the best way to eliminate anti-selection. There will be people left out if we only look at the employer groups.

Mrs. KENNELLY. So you think that if we eliminate employer mandates, that all of a sudden, everybody will march forward and get their insurance?

Mr. GUMMERE. Oh, no, no. Actually, I am in favor of some kind of encouragement that employers make health insurance available.

Mrs. KENNELLY. But not mandated.

Mr. GUMMERE. To achieve universal coverage, I believe individuals should meet that obligation. I think that employers should continue to pay as they are today.

Mrs. KENNELLY. You have done fairly well under the system of employer-provided health care?

Mr. GUMMERE. Right.

Mrs. KENNELLY. Thank you, sir.

Ms. JENCKES. Mr. Chairman, I would just like to make one other comment and this is relative to the HIAA proposal for reform. I don't know why under your scenario, with having Medicare compete with us, and we look forward to talking to you a little bit more about it, you would want to do that particularly since we are for guaranteeing issue of health insurance no matter how high the health risk a group represents.

Why would you want to be the backstop for those people?

Chairman STARK. Because I figure that I set up a cost standard as well. And there has to be—when you say you will take all



comers, that doesn't mean that you are going to go out and beat the bushes in Alaska or the everglades of Florida to find some people who have been overlooked. So that—

Ms. JENCKES. In a mandated environment they have to find us, and we are there. If we are licensed to do business, we have to guarantee the product.

Chairman STARK. I understand. But believe me, we have testimony, so don't embarrass some of your members, but there are members who have made an art form of avoiding certain groups of people. And all I am saying is that let's just assume that there just might be two or three people.

Hawaii has got a mandate, but it is still 6 percent, and you know, 6 percent is 15 million people. That is not acceptable. I mean there is 15 million people right there that somehow, even if we do as well as Hawaii, there will be impoverished people, there will be children without parents, there will be a whole host that we still haven't dealt with, prisoners and undocumented people, there are just a lot of people.

We have the other side of the coin, where we have an access problem. That troubles me. We have much more coverage under Medicaid than we have access. We have a lot of people who are eligible for Medicaid and they can't get anybody to treat them at the rate.

So there is a couple of things we have to do in the Federal Government anyway. We have to deal with the impoverished population where—and we can't force you to. We can force you to accept, but we are not ready and you are not ready to agree that we start having risk pools where we hand people out. The doctors like it even less.

So that is not apt to happen. So all I am saying, truthfully, is if we are going to guarantee every person health care, we have to perform on the guarantee. And if nobody comes, you won't hear a peep out of me.

I don't intend to get on the next Ed McMahon on late night television and try to encourage people to sign up. But I will rest easy then and say OK, then I can say to anybody in my district who is complaining, I say hey, here is Medicare and then there is 101 supplemental policies out there, or if you are poor, we will cover the company-pays just like we do in Medicaid or Medicare for the impoverished, but we just broaden it.

We take Medicaid into it, the doctor and your plans, those of you who operate plans won't know whether I am poor, elderly, or both. They will just know that I am in a plan. I might be a government employee. We might have to be in that plan.

But my point is that I think it is not realistic to assume that there will be no government plan. I just don't believe that. And as a matter of fact, I don't think that is a very good idea.

Chairman STARK. But I am just saying, if I spot you, an open season, on what you want to sign up on, why can't you be in there and the public can truly choose? I don't think that politics will be such that we will be offering the Cadillac plan. We are not doing it, as you all know, now under Medicare. It is quite the opposite. We are sitting here cutting. And if you want to bet me on what is

going to happen in the next couple of weeks, we will probably start doing some tough cuts on beneficiaries.

So I am not so worried that we are going to run away and have the highest option plan in the marketplace at the lowest cost. I think we will be able to maintain a plan with choice, which we will do probably because we will have to, and many of your companies won't, they will move to a managed group. We will probably have to keep a fee-for-service option alive. Our rate setting for that will probably be the model that most of your members will use, and if you use rates higher, that is OK with me, that is up to them. If we were asked, we could do it. We could expand the Medicare system and set a different set of rates.

States could do it. But then you don't care. Then suddenly all of this bureaucracy and the National Board of the State alliances would say, hey, we have covered everybody. What you don't, we do. What you want to bid on, you bid on. And our balance is that if you go up too high in your costs, our plan will look relatively more attractive, so we will perhaps come to an equilibrium from the private side to the public side.

Mr. Cunningham, it could lead to a single payer system. My guess is if that happens, it happens over 10 years rather than by fiat. It could lead to the privatization of Medicare if it happened that way. I will sign on. I have got a risk—this was raised by my staff. What happens if we set basically a national rate, and in South Dakota, we are underbid? I mean, I have got to play by the same rules I am laying down. If somebody comes in and bids, then you privatize Medicare in South Dakota. It is OK with me.

It is the only way I see out of the box, quite frankly. I am looking around, I can't find a hundred votes for any plan right now, and I can't find a critical mass that will bring people together. If I give these guys, Mr. Cunningham and Mr. Katz, \$4 a month for every one they sign up, they will sign up for my Medicare plan in a minute, \$5.

Mr. KATZ. We will talk.

Mr. CUNNINGHAM. We just want to maintain a real playing field on this. We will be happy to look at it. As I said, it is rather a new concept. We would have to mull it over. We would love to talk about it further with you. The situation is, would the playing field remain level; could we identify the groups of people where the coverage isn't? Maybe that is what we ought to look at more specifically as opposed to trying to go out and compete with each other all the time.

Chairman STARK. Well, we would be basically passing back some, as we see it. Yes, we have a price that would be in the market, but for some insurers, it would be just to sell a wraparound plan, that would be very attractive. If we are low with the minimum benefit and we take all the long-term risks, all a creative marketer has to do is wrap a package around it and sell it, which is what I suspect would happen. Before you see a single payer involved, you would find people marketing complete plans. Certainly HMOs would. Or managed plans. We would be in the business then of paying a premium, quite frankly.

That is what we do with risk contracts. You want a risk contract under Medicare, we pay the premium. We have to figure out how

we set that premium, because the President and Medicare do it differently. But it sure is simple.

Well, listen. Thank you. It has been helpful. I appreciate your indulging my whimsies. We will work with you more as we wind through this.

Mr. KATZ. It is an intriguing concept even if we have to become a union as a result.

Chairman STARK. If you are looking for a bargaining agent—the meeting is adjourned.

[Whereupon, at 3 p.m., the hearing was adjourned.]

[Submissions for the record follow:]



ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS  
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Statement of  
The Association of State and Territorial Health Officials (ASTHO)  
Before the  
Committee on Ways and Means  
U.S. House of Representatives  
February 28, 1994

Mr. Chairman and Members of the Committee:

The Association of State and Territorial Health Officials (ASTHO) represents the chief health officer in each state and U.S. territory. We are pleased to present written testimony for the record on behalf of state public health agencies.

We commonly think of public health services as those such as identifying and controlling disease outbreaks; immunizing children and adults; protecting the indoor and outdoor environment; assuring the safety of housing, workplaces, food and water; and monitoring the quality of health care services. These activities target the entire population to create an environment in which communities can be healthy, rather than targeting individuals. Traditional public health has, in many cases, been undermined as many state health agencies have diverted much of their attention to health care delivery for individuals who cannot otherwise receive adequate care through normal health care delivery channels.

However, in recent years this country has been challenged with new and re-emerging public health crises as a result of inattention to basic public health services. Last year we saw several children die because they ate hamburgers contaminated with E. coli. Numerous people were sickened in Milwaukee from Cryptosporidium which went undetected in the water supply for weeks. Just last week, it was reported that more health care workers are dying of tuberculosis, an increase which can be attributed to decreased surveillance in TB programs resulting from funding cuts in the 1980s.

Why are these crises occurring in spite of soaring health care expenditures and the availability of the most sophisticated technology in the world? We believe it is because we are spending much of our time and resources fixing problems rather than building a foundation for preventing them. For this reason, state health officers look forward to a reformed health care system which will allow us to re-focus on our primary responsibilities, which we now call "core public health services."

In looking at reform proposals currently before Congress, however, it is important to point out that many reform only the "care" aspect of health care - that is, they focus on the delivery of services - and do not address population-based health protection. If we truly want to reform the nation's health care system, as well as control spiralling costs, we must put the "health" back in health care reform by focusing on population-based preventive health services.

ASTHO applauds the Administration's strong commitment to public health and prevention illustrated in the President's health care proposal. The eight Core Functions of Public Health Programs listed in the Health Security Act represent essential services which must exist in every state. However, to build a strong public health foundation for health care reform, we must continue to strengthen reform legislation.

Core public health functions are those activities deemed essential to protect the health of the population. These include data collection, protecting the environment and assuring public safety, investigating and controlling adverse health conditions, informing and educating the public, providing quality assurance of health services, monitoring laboratory services, providing training and education of health professionals, and taking a leadership role in health policy development. ASTHO believes that these essential services are too critical to be supported through a competitive process, in which some states will receive funding at the expense of other states' programs. Competitive funding for core services will only ensure that states which are weak in providing public health services and in competing for grants get weaker. To allow any state not to conduct activities such as disease surveillance or investigation of disease outbreaks would compromise the effectiveness of such programs nationwide. We believe that grants should be awarded using a formula which includes a state's population and health risk indicators.

Second, the President's bill states that the Secretary of Health and Human Services may fund "one or more" of the eight core public health functions. By their very definitions, we believe that the eight functions listed are critical to the **population** as a whole, and should not be funded at the discretion of the

Secretary.

Third, states must have a designated, predictable source of funding for core public health programs - specifically, one that is tied to total health expenditures. In many cases, if there is not consistent federal funding, state legislatures cannot authorize staff hiring or set aside resources for matching funds. In addition, given the history of the Congressional appropriations process, it is likely that public health will receive in appropriations much less than the authorization amounts. These realities, combined with the fact that there is no mention of maintaining current block grant funding, places the future of public health funding in serious jeopardy. We must re-think and re-design our approach to public health funding in order to develop a foundation of prevention in health care reform. ASTHO also believes that additional funds for special projects and state priority areas should be channeled through state health departments to communities to assure coordination and reduce duplication.

Fourth, we would like to state clearly that states welcome accountability for public health funding, but ASTHO believes that accountability should be based on monitoring outcomes, not on managing the process of achieving outcomes. Outcome measurements should be based on progress in meeting objectives outlined in the *Healthy People 2000* document, as well as in implementing the eight core functions.

Fifth, data collection is considered a core function in the President's proposal. Public health data systems are used to identify clusters of diseases or other changes, such as a surge of teenage pregnancies, which provides warning that the public health system must intervene. Public health investigations can lead to increased efforts to immunize children, to improved outreach to specific communities, or to a public information campaign designed to increase awareness. No regional health maintenance organization or health alliance will be able to monitor statewide trends or identify urgent and emerging health problems. Therefore, it is critical that states play a central role in developing and implementing any data collection systems to assure that population-based data, as well as encounter-based data, is available in a reformed health care system.

Finally, it is critical that public health professionals are included in the development and implementation of a reformed health care system. Public health representatives should be included on all advisory committees and councils to assure that prevention is a high priority. In addition, it is crucial that training programs for public health and preventive medicine be eligible for federal health professional support.

In summary, as you examine the various health care reform proposals currently before Congress, we respectfully request that you keep the following items in mind: dedicate a guaranteed source of funding for public health; require that states make available each of the eight core public health functions and assure that federal funding is available for each; utilize a grant process which assures all states of funding necessary to carry out the core functions; hold states accountable by evaluating progress toward the *Healthy People 2000* objectives; ensure that data are available to state health agencies and that population-based data are collected; acknowledge the unique expertise of public health professionals by designating public health seats on each advisory council; and adequately support public health training and education programs.

ASTHO would like to emphasize that state health agencies are statutorily responsible for maintaining the health of all residents in states. We are the only entities which will continue to have statewide responsibilities after health care reform is implemented. We look forward to working with you and the Administration to pass and implement a reformed health care system which will benefit the population as a whole.

Thank you for this opportunity to present testimony for the record.

## Supplemental Sheet

## Summary:

1. **Keep "health" in health care reform: make sure that public health functions are funded so that we can keep people healthy, rather than waiting to provide expensive "care" when they get sick from preventable illnesses.**
  - Guarantee that the public health system in every state is funded to provide core functions by dedicating a fixed percentage of national health spending to public health.
  - Make sure that all states, not just the best competitors receive funding for public health by allocating public health dollars based on population and health risk factors.
  - Reauthorize current block grant and categorical public health funding for five years in reform legislation to assure that necessary services are not eliminated during the transitional period. After five years the need for continued funding should be reassessed based on documented health status and public health indicators.
2. **Make governmental public health agencies accountable for outcomes, and give them the tools to be accountable.**
  - Mandate that all funding for public health be administered through public agencies in order to assure that state goals and objectives are being met through local initiatives, and to eliminate duplication of efforts.
  - Require that supplemental services programs such as enabling grants and services for children with special health care needs be distributed to states on a formula basis and administered by the state health agency, based on a community planning process. This will assure that grants address statewide priority areas and are coordinated with other public and private programs.
  - Hold health care and public health systems accountable by measuring progress in meeting national health status objectives laid out in the Department of Health and Human Services plan, *Healthy People 2000*.
  - Simplify federal data requirements, to spend less on reporting duplicative data, and to spend more effort collecting data that reflects the results of public spending for health. Provide support to strengthen public health data systems which provide information needed to predict and monitor health trends and potential problems of the entire population and supplement the new data system, which is based on individual encounters with practitioners.
  - Require that purchasing alliances and cooperatives have formal relationships, including data sharing, with public health agencies, to assure that appropriate monitoring will occur. State health agencies must have the option to serve as the collection point for data to be sent to regional data centers, or to serve as the regional data center.
3. **Build public health professionals into health care reform.**
  - Establish a National Advisory Council on Public Health Priorities, to examine the nation's health and set a course of action which will prevent health crises before they occur.
  - Put the prevention framework into every advisory body and commission established in reform initiatives by establishing a mandatory public health seat on every board, council and commission.
  - Put prevention into practice by supporting prevention research and demonstration projects in the Centers for Disease Control and Prevention and by supporting training and education of public health professionals through programs authorized in reform legislation.

For further information regarding this statement, contact:

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Submitted by:

David Swankin, Rebecca Cohen, Debi Tucker

**Statement for the Record Submitted by the Citizen Advocacy Center (CAC) on an Appropriate Role for State Health Care Licensing Boards under Health Care Reform**

The Citizen Advocacy Center (CAC) is a unique support program for the thousands of public members who serve on health care regulatory boards and governing bodies as representatives of the consumer interest. Whether appointed by governors to serve on regulatory boards or selected by private sector institutions to sit on a board of directors or advisory panel, public members are usually in the minority and are without the resources and technical support available to their counterparts from professional and business communities. CAC was created to fill this gap by providing research, training, technical support, and networking opportunities for public members.

CAC's goal is to equip public members to be advocates for excellence -- to continually press their boards to serve public policy goals more effectively and efficiently. To this end, CAC disseminates information and provides forums for the examination of public policy affecting health care delivery and regulation. CAC distributes a quarterly publication entitled *Citizen Advocacy News*, produces research reports on topics of current and practical concern to public members, holds an annual conference, and conducts training seminars for individual states, regulatory bodies, and others.

CAC began in 1988 as an autonomous program of the American Association of Retired Persons. By January, 1994, CAC had matured into an independent organization and was incorporated as a 501(c)(3) nonprofit, governed by its own board of directors. CAC intends to continue its proven program and expand its reach to include public members of federal and state health care reform agencies as well as additional health care provider licensing boards.

We are pleased to share some of our thoughts about an appropriate role for health care licensing boards now and under health care reform. We believe the role of licensing boards should continue to be to protect the public health and safety by assuring that 1) applicants who obtain a license possess at least the minimum acceptable qualifications to perform the tasks expected of a member of the profession, and 2) licensees whose job performance falls below minimally acceptable standards of competence and conduct are disciplined -- that means either remedial action or license revocation depending on the severity of the offense.

Our experience with CAC has led us to conclude that there are two bottom-line measures of effective board performance. First, boards must be proactive guardians of the *quality* of care. Second, boards must not impose limitations on professional practice that unnecessarily restrict *access* to care or unjustifiably raise the *cost* of care.

In our view, much more attention needs to be paid by lawmakers to the duties, responsibilities, and performance of state health professional licensing boards if whatever health reform legislation emerges is to deal adequately with quality of care. Licensing boards are the most important and powerful gatekeepers on the provider side of the equation. They decide who may and may not deliver what types of health care services in the first place. They have the power to remove from practice licensees whose practice falls below established minimum levels of competency.

Unfortunately, licensing boards do not always fulfill their responsibilities. That should seriously concern us all because no other institution is positioned to enforce baseline standards of quality of care. For a time, it appeared that the Medicare Peer Review Organizations (PROs) could share the responsibility for monitoring individual practice, and weeding out those whose practice fell below minimum standards. That has not proven to be the case, and few argue that the PROs ought to be given that role under health care reform. Rather, it appears it will be the job of the PROs to look at patterns of practice, not to discipline outliers. This means that like the rest of us, PROs, or whatever new institutions replace them, will have to rely on state health professional licensing boards to take action against practitioners whose practice falls below acceptable minimum standards. And, PROs, or their successors, should be *required* to share with

licensing boards any information they discover about substandard practitioners. In 1992, CAC conducted a 50-state survey that showed very little, if any, exchange of information between PROs and licensing boards. This was so even though both PROs and Boards heartily endorsed the idea of information sharing. We concluded then that only a legislative mandate would make information sharing a reality and we recommend that be part of any health care reform bill.

Getting back to health care licensing board responsibility for safeguarding quality of care, we agree with critics that licensing boards should not be entrusted with quality of care functions under health reform unless they demonstrate a willingness to perform at a level that does indeed protect the public. In a letter to the editor carried in the Summer, 1993 edition of the *Federation of State Medical Boards' Bulletin*, David Swankin, a CAC Director, commented as follows:

"How to assure quality of care and who to rely on to be an effective monitor, are not easy questions to answer. Many players will be involved in whatever new system emerges, so simplistic formulas will not suffice. But whatever the mix, state licensing boards most certainly are well positioned to be prominent among the players. This idea seems so obvious to those of us who work in the licensure field that it is hard to understand why so many of the architects of health care reform ignore licensing boards in their plans....

"But how do we respond to the critics who say, 'licensing boards can't be trusted with quality assurance responsibilities, because their track record is poor.' As you know, I am one of those in the public interest community who has often criticized boards for failing to give quality of care cases at least as high a priority as drug diversion, chemical dependency, and sexual abuse cases. Important as these cases are, nothing is *more* important than pursuing substandard quality of care cases. The primary function of the state licensing boards is to assure that practitioners meet minimum levels of competence to assure public health and safety. Many licensing board members and their staffs candidly admit that the percentage of quality of care cases in the case load mix is smaller than it should be. They explain that it is time-consuming and costly to take on quality of care cases. They are difficult to investigate and to win.

"In many states, licensing boards, and in some cases the umbrella agencies that conduct the investigations and prosecute the cases for the boards, acknowledge that they shy away from quality of care cases.... Boards will have to pay more attention to quality of care cases if they want to be taken seriously when they ask for a major quality assurance role in the future health care reform."

Other leaders in the licensure field feel the same way. Stephen Seeling, JD, Executive Director of the State Board of Medical Examiners of South Carolina, commented on the above-quoted letter by writing:

"[T]he litmus test for medical boards in the '90s must be quality of care cases. This is not to minimize the egregiousness of physician sexual misconduct. Sexual misconduct is a gross exploitation of the physician-patient relationship which violates any standard of professionalism and decency. It is boards' handling of quality of care cases, however, that will determine whether boards survive this decade. Yes, survive. Swankin, in his eloquent and incisive letter, said it best: 'Nothing is more important than pursuing substandard quality of care cases.' Borrowing a strategy from the 1992 Presidential campaign, every board executive director should have a sign in the office: 'It's quality of care, stupid.'"

Consistent with what CAC considers to be the second basic measure of performance: that licensing boards should not impose restrictions that unnecessarily interfere with access to care or unjustifiably add to costs, Section 1161 of HR 3600, the Administration's Health Security Act, provides that:



"No State may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals."

Recently we became aware of a January 26, 1994 letter sent by William Marcus, President of the Council on Licensure, Enforcement and Regulation (CLEAR) to the members of Congressional committees that are considering health care reform legislation. We were surprised that an officer of CLEAR, which is an affiliate organization of the Council of State Governments, would interpret Section 1161 of the Health Security Act to be, in his words;

"... broad and so vague that it would eliminate the ability of any state to restrict the practice of any person who claimed to be within a class of health professionals and who claimed to have some skills and training, almost without reference to the validity of the claim....

"Section 1161 would make it virtually impossible for states to effectively control shoddy or charlatan practitioners, and I do not have confidence that the federal government is able or prepared to establish the massive bureaucracy which would be necessary to set standards or enforce them.

"If Section 1161 passes and state licensing boards continue to exist, they will be paralyzed by the inability to develop standards under the language of Section 1161 (or even to determine which boards could properly continue to exist) and by the inevitability of multiple lawsuits by any persons or class of people who felt they had been wronged either by the general standards of the licensing board or by the action of the board in any specific case."

CAC strongly disagrees with the views expressed by Mr. Marcus. To the contrary, we consider Section 1161 to state one of the golden rules of licensure in the public interest. If the legislative language is cast in the negative, it is because licensing boards have been known to overstep these important boundaries.

We urge Congress to go beyond the powerful and important concept reflected in Section 1161 and include in federal legislation either incentives or penalties, or some combination of the two, to make boards achieve new heights of public protection. On the *carrot* side of the equation, boards that perform according to criteria set forth in the legislation could be eligible for financial assistance to supplement their present budgets, whether in the form of grants-in-aid, or a percentages or surcharge on insurance premiums.

On the *stick* side, health care reform legislation could give the federal government regulatory authority. Congressman Pete Stark (D., California) once threatened to enact federal relicensure and retesting requirements. That effort was short-lived and we believe any present effort to impose federal regulation over state licensure would be both inappropriate and doomed.

We recommend a non-regulatory approach and suggest that health care reform legislation require states wishing to receive financial support to file a plan with their state health alliance, or whatever appropriate institution is created under health care reform, indicating 1) how they would meet specified criteria and 2) how they would document continuing conformance with their plan. Once this two-fold plan has been approved, financial assistance from a direct appropriation, insurance surcharges, or some other source would be awarded so long as the board met its plan.

To become eligible for financial assistance, the plans would have to show that a licensing board can meet at least the following criteria:

- I. Show that public members are fully functioning participants in every aspect of board work, as evidenced by:

- a) at least 1/3 and ideally 1/2 of the board is public members
  - b) at least one public member is present on every board committee or panel
- II. Show that the Board's legislative mandate, rules and regulations do not contain unnecessary restrictions on entry into the profession, unnecessary limitations on the scope of practice of this or allied professions, or unjustified business practice restrictions unrelated to professional competence or public health and safety.
- III. Show that the Board does not ignore its responsibility to assure minimum competence as evidenced by:
  - a) In addition to the numerous substance abuse, drug diversion, and sexual abuse cases, the board also pursues cases alleging incompetent practice
- IV. Show that the Board manages its case load, as evidenced by:
  - a) A system for prioritizing cases/complaints
  - b) Procedures ensuring prompt investigation of all cases, in no case more than 6 months from receipt of a complaint or report;
  - c) Intervention guidelines for tailoring the disciplinary or educational intervention to fit the infraction
  - d) Cases are brought to the point of a final board action within a reasonable time frame for the nature of the violation, and in any case no longer than 9 months from the time probable cause has been determined;
  - e) When cases are resolved by consent order or voluntary agreement rather than evidentiary hearing, the negotiated settlement should fit the intervention guidelines
- V. Show that Board takes steps to be accountable to the public it serves, as evidenced by:
  - a) Publication of an annual report documenting performance;
  - b) A proactive program to release information about disciplinary activity, including publicizing the name and offense of all licensees disciplined by the board and requiring that the names of licensees be made public at the time a board determines there is probable cause to initiate a disciplinary proceeding;
  - c) A Board-sponsored outreach program including publications and speakers bureau;
- VI. Show that if the board sponsors or endorses a program for impaired professionals, the board exercises an appropriate level of oversight over the program and is aware of the identity of all licensees who are enrolled in the program
- VII. Show that the Board regularly reviews its operating statistics, as well as its statutes, rules and regulations, and takes initiatives to improve operating effectiveness and efficiency and prepares legislative recommendations when appropriate to strengthen its authority
- VIII. Show that Board members are prepared to perform the job and trained in effective boardmanship, as evidenced by:

- a) Board members receive orientation training
- b) The Board supports travel of public as well as professional members and staff to training seminars and conferences on substantive and policy issues

Thank you for an opportunity to share our views. We would welcome an opportunity to participate in the development of a strong support program to help state licensing boards effectively perform their important functions.



## **PRESIDENT'S HEALTH CARE REFORM PROPOSALS: ISSUES RELATING TO RISK SELECTION AND ADJUSTMENT BY HEALTH PLANS**

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**TUESDAY, NOVEMBER 9, 1993**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON HEALTH,  
*Washington, D.C.*

The subcommittee met, pursuant to call, at 10:10 a.m., in room 1310-A, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. Good morning and the subcommittee will continue their health reform hearings. Today the topic is risk selection and risk adjustment and while this may seem an arcane and technical topic, it has critical implications for the success of the President's health care reform package.

One of the major reasons that health reform has moved to the top of the agenda is the rampant risk selection used by the private health insurance companies, particularly in the markets for individual and small group insurance.

The insurers have become experts in the art of risk selection and have learned that that is the easiest way to save money is to screen out the risks rather than take any steps to really manage health care costs. By now the stories are all too familiar. Individuals are turned down for preexisting conditions, canceled after claims are made, small employers are forced to exclude certain workers or dependents with health problems, premiums are escalating, a host of stories.

The purpose of insurance is to pool risk among a large group and, in a given year, most people will pay premiums and stay healthy enough so that their premiums will exceed the value of their benefits they get back. This excess contribution should cover the costs of the small number of people who get very sick and need the most costly medical care.

Segmenting the health insurance market has meant that health risks are not being pooled across a large enough population and for the relatively young healthy people, this segmentation keeps premiums low, but for too many others like Mr. Thomas and myself, the segmentation of the market has made health insurance a higher cost item.

Some sort of risk adjustment is needed under any proposal to reform the private insurance market in order to discourage the insur-

ers from engaging in this risk selection and to appropriately compensate insurers that enroll a disproportionate share of high-risk individuals, hopefully in a random fashion.

The administration's plan relies on risk adjustment to modify payments to health plans for the potentially uneven distribution of these high-cost cases. The need for the risk adjustment takes on greater importance in the administration's plan because of the proposed policy to cap premium payments to health plans.

Under these caps, if you didn't have adequate risk adjusters to compensate, most plans with a high-risk population, the health plans would continue to discourage enrollment of high-cost individuals or be forced to limit services provided to those most in need. The premium caps would exacerbate existing incentives to engage in sophisticated risk selection activities.

Of particular concern is the potential impact on inner city residents and other high-risk populations. Without an effective risk adjustment system, health plans will be motivated to avoid providing services to these traditionally underserved populations.

Unfortunately, there are no risk adjustment tools in existence today that we can use to carry out the requirements of the President's plan. Those who have made careful review of the literature would have to recognize that reality. Even the administration acknowledges that the methodology for risk adjustment is still in its so-called developmental stages.

I put it right up there next to "Star Wars" as a practical reality. The questions before us are these: Should we enact a health reform plan that relies on a system of risk adjusters that don't exist, and what are the consequences of moving forward without these risk adjusters? Can we protect access for high-risk individuals?

We are fortunate to have with us today a number of experts who can help us answer these questions and certainly help us understand the implications of risk adjustment or lack thereof in the health reform proceedings.

I would like to at this point recognize Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I, like you, am very interested in this particular hearing because of the importance of risk selection and risk adjusting. One expert that we worked with likened it to gravity. If you are going to plan a trip to the Moon and don't take into consideration the Earth's gravity and the Moon's gravity, you are going to have a degree of risk, and it is fundamental.

Mr. Chairman, I think the health care reform battle can kind of be broken down into the political problems and the real world mechanical problems, and I put this one in the real world mechanical problems. The question of funding, how it is funded, whether or not we mandate universal coverage, how much is funded, the time line for that is all a matter of will and in the political category, but the questions of risk selection and risk adjusting, I think, fall under the category of can we do it, do we have the data necessary, either at the State level, which would be fundamental, or in subunits of States, depending upon how the alliances are going to be structured, and if the answer is yes, can we do it early on, can we do it at the beginning?

Because up front, the President's plan requires adjusting from day one and then on, and if we can do it early on, can we do it accurately so that we don't make mistakes that continue to compound even through the first year or the second year?

So although it is simply one of those line listings of powers under the National Health Board, regardless of whatever plan we move to, if we are going to move to universal coverage, which I believe now is not a question of yes or no, but a question of when and how, risk selection and risk adjustment are fundamental to making it work and, Mr. Chairman, I, like you, am anxious to hear additional experts.

It seems to me that there might be a possibility, since the private sector has gotten so good in risk selection and risk adjusting, we might want to focus on that area of reverse engineering and see if their ability to carve out subsets within the universe might be utilized in a reverse process to figure out how to deal with the whole universe, and I look forward to their testimony.

Thank you.

Chairman STARK. Are there other statements or comments before I introduce our first witness, who is Dr. Kenneth Thorpe, who is Deputy Assistant Secretary for Health Policy in the Department of Health and Human Services? He will outline for us the administration's perspective on the risk selection and risk adjustment. He is accompanied by his Special Assistant, Gary Claxton, and by James Lubitz, the Chief of the Analytical Studies Branch, the Office of R&D in the Health Care Financing Administration.

Welcome to the committee, Dr. Thorpe, and your written statement will be made part of the record in its entirety, and you can enlighten us, expand on it in any manner you are comfortable.

**STATEMENT OF KENNETH THORPE, PH.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION; ACCOMPANIED BY GARY CLAXTON, SPECIAL ASSISTANT TO THE DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY; AND JAMES LUBITZ, CHIEF, ANALYTICAL STUDIES BRANCH, OFFICE OF RESEARCH AND DEMONSTRATIONS, HEALTH CARE FINANCING ADMINISTRATION**

Mr. THORPE. OK, thank you, Mr. Chairman, members of the subcommittee, we appreciate the opportunity to appear before you today to discuss how the Health Security Act proposed by the President addresses the problem of risk selection in the health insurance markets.

Risk selection, particularly the intentional exclusion by health insurers of people with serious or chronic health problems, is one of the most significant obstacles to health security in our current health care system.

The Health Security Act addresses risk selection through a series of integrated steps. These include: First, assuring universal coverage for comprehensive benefits; second, enrollment and marketing reforms; third, insurance underwriting and rating reforms; fourth, reforms in planned contracting rules; fifth, mandatory reinsurance of high-cost cases and conditions; and finally, adjustment

of health plan premiums for demographic and health status variations.

Each of these steps will be summarized below.

Risk selection is important because it can distort competition among health plans. Risk selection occurs when a health plan attracts a mix of enrollees that is healthier or sicker than average. The problem of risk selection is important because it affects the premiums charged by health plans. If the premiums of competing health plans reflect risk selection rather than the efficiency and quality of the plans, the benefits of competition are diminished.

Risk selection can result from behavior by health plans or from decisions of individuals. Health plans contribute to risk selection through the use of various techniques to discourage enrollments by higher risk people and attract healthier enrollees. In the current marketplace, insurers use medical underwriting, preexisting condition exclusions, minimum group participation requirements, and industry exclusions to prevent enrollment by poorer risks. Even in a reformed market which eliminates such practices, insurers can still attempt to influence the composition of their enrollment through their decisions on which providers to contract with and where to locate service areas and facilities, as well as the amount of service and support to provide high cost patients.

Individual consumers can also contribute to risk selection though it is often referred to as adverse selection. Adverse selection occurs when individuals change their decisions about purchasing insurance because they need health care in the near future. Adverse selection can occur even in a reformed market if high risk people systematically select particular health plans, such as health plans that have lower cost sharing or that offer more choice of health care providers.

The strategies used by the Health Security Act to address risk selection can be summarized as follows. First, universal coverage and comprehensive benefits. The requirement that everyone have coverage for the comprehensive benefit package naturally reduces adverse selection in the markets. Universal coverage means that people cannot wait until they are sick to seek coverage.

Standard comprehensive benefits mean that health plans will be forced to compete on price and quantity—quality, not on minor differences in health care benefits that they offer.

Second, enrollment and marketing reforms. Providing for marketing and enrollment through health alliances removes the opportunities for health plans to use selective marketing and other types of underwriting to discourage high-risk people from enrolling.

The Health Security Act provides for regulation of any direct marketing by health plans.

Third, satisfaction and disenrollment surveys. One potential means of risk selection by health plans in a reformed system is to discourage higher risk enrollees from continuing with the health plan by giving them poor service or failing to contract with providers that can address special needs.

The Health Security Act provides for enrollees to be periodically surveyed to detect problems with health plans' service. People who switch plans can be surveyed to determine if they left the former plan because of poor service or inadequate access to specialists.



Fourth, insurance reform. By requiring health plans to accept all applicants, use community rating, and guarantee renewability of coverage, the Health Security Act eliminates many tools now used by insurers to select favorable risks.

Fifth, health plan contracting requirements. There is some concern that health plans will avoid contracting with leading treatment centers and specialists in order to avoid patients with serious health conditions.

The Health Security Act addresses this concern by requiring health plans to contract with academic health centers for the treatment of health conditions that require the specialized treatment and expertise of these centers.

This requirement will assure that enrollees who need special services will be able to select and stay in any plan serving their area.

Sixth, risk adjustment and reinsurance methodology. The Health Security Act requires the National Health Board to determine a risk adjustment and reinsurance methodology to be used by regional alliances. The act directs the Board to consider a number of factors in developing the methodology, including demographic characteristics, health status, geographic residence, socioeconomic status, and the proportion of cash assistance recipients enrolled by a plan.

The Health Security Act provides for several methods of protecting health plans from adverse selection by higher cost enrollees. In the short term, we expect the Board to rely on a combination of demographic and area adjustments, plus mandatory reinsurance programs.

The Board also may require health status adjustments based on self-reported health status collected through the surveys of plan enrollees. Over the near term, we expect the Board to develop and implement more sophisticated adjusters for health status based on diagnosis of plan enrollees.

Over the last few years, the Department of Health and Human Services has sponsored and conducted a substantial amount of research looking at the development of risk adjusters for health status primarily related to the Medicare population.

To accelerate development of risk adjustment methodologies for the under 65 population, the department is currently developing a work plan that encourages research efforts in this area. The work plan will call for internal research efforts and for sponsoring research and demonstration by outside experts.

In conclusion, the Health Security Act uses a variety of strategies to address the risk selection problems that plague the existing health insurance markets. We believe that these strategies will encourage competition among health plans on the basis of price, quality and service.

We would all be happy, Mr. Chairman and Members of the subcommittee, to answer any questions you may have on the President's plan.

[The prepared statement follows:]

**TESTIMONY OF KENNETH THORPE  
DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY  
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. Chairman and members of the Subcommittee, we appreciate the opportunity to appear before you today to discuss how the Health Security Act proposed by the President addresses the problem of risk selection in the health insurance market. Risk selection -- particularly the intentional exclusion by health insurers of people with serious or chronic health problems -- is one of the most significant obstacles to health security in our current health care system.

The Health Security Act addresses risk selection through a series of integrated steps, including: assuring universal coverage and comprehensive benefits; enrollment and marketing reforms; insurance underwriting and rating reforms; mandatory reinsurance of high cost cases and conditions; and the development of risk adjustment for premiums paid to health plans for demographic and health status variations in plan enrollment.

The problems of risk selection and the steps taken to address them by the Health Security Act are discussed below.

**The Risk Selection Problem**

The Health Security Act uses a reformed, private health insurance system to assure universal coverage for all Americans. All individuals will have coverage for comprehensive benefits provided through competing health insurance providers (called "health plans"). To assure that health plans operate efficiently and remain responsive to consumers, families will be given an opportunity each year to choose a new health plan or to remain in their current plan. By providing the actual consumers of health care the opportunity to make informed choices about which health plan to enroll in, the Health Security Act encourages health plans to compete for enrollees on the bases of efficiency, quality and service.

Competition among health plans responding to informed consumers will produce lower premiums, better quality and improved consumer satisfaction. Competition can become distorted, however, by risk selection.

Risk selection occurs when a health plan attracts a sicker or healthier than average population. The problem of risk selection is important because it affects the premiums charged by health plans. If risk selection occurs, health plans that attract relatively healthier enrollees will have relatively fewer and less expensive claims and can charge lower premiums.<sup>1</sup> On the other hand, health plans that attract relatively sicker or higher-risk enrollees generally will have higher expenses than plans with average enrollment mixes, and will be required to charge higher premiums to cover their higher costs. If the premiums of competing health plans reflect risk selection, the benefits of competition -- which are to promote efficiency and quality -- are diminished.

Health plans now can contribute to risk selection through the use of various techniques to discourage enrollment by higher-risk people, and to attract healthier enrollees. In the current marketplace, insurers use medical underwriting, preexisting condition exclusions, minimum group participation requirements, and industry exclusions to prevent enrollment by poorer risks.

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<sup>1</sup> Health insurers can generally manage the risks associated with random occurrences of illness and injury in a large pool of enrollees. However, competition in a health insurance market is diminished if the enrollment choices of consumers are systematically biased in a way that particular health plans attract a markedly healthier or sicker than average mix of enrollees.

Even in a reformed market which eliminates such practices, they can still attempt to influence the composition of their enrollment through their decisions on which providers to contract with, where to locate service areas and facilities, and the amount of service and support to provide higher-cost patients.

Individual consumers also can contribute to risk selection through their decisions about when to purchase insurance and the level of coverage to purchase. In the current market, consumers who know they are in poor health or at higher risk for needing health care services are more likely to choose to insure and to choose more extensive benefits when they do insure. This tendency is often referred to as "adverse selection." In a universal, reformed market, adverse selection could still occur if higher-risk people systematically select particular health plans (e.g., health plans that have lower cost-sharing or that offer more choice of health care provider).

#### **Addressing Risk Selection Problems**

The Health Security Act employs a number of strategies to address the problem of risk selection. Universal coverage by a guaranteed benefit package, changes in marketing and enrollment practices, and reforms in insurance practices all will reduce risk selection in an informed health care marketplace. Changes in health plan contracting practices, including requirements that health plans contract with academic health centers and essential community providers, also address part of the risk selection problem by assuring that enrollees will have access to needed specialists and expertise in every health plan. In addition, the Health Security Act requires the National Health Board to develop a risk adjustment and reinsurance methodology to be used by regional alliances to further address risk selection problems.

The strategies used by the Health security Act to address risk selection are outlined as follows:

##### Universal Coverage and Comprehensive Benefits

- Universal coverage. In the current system, insurers worry that people with or at high-risk for health problems are more likely to seek coverage. Insurers use medical underwriting, preexisting condition exclusions and other mechanisms to protect themselves from adverse selection.

Under the Health Security Act, everyone is required to have health insurance coverage. People will not be allowed to wait until they have health problems before obtaining coverage.

- Uniform comprehensive benefit package. In the current system, insurers worry that less healthy people tend to choose richer benefits. Insurers often design their benefit packages to attract younger, healthier enrollees.

Under the Health Security Act, everyone will have the comprehensive benefits package. Health plans will be unable to influence enrollment decisions through the design of their benefit packages. In addition, because all plans will offer comprehensive benefits, there will be less reason for people to change health plans if their health status changes.

##### Enrollment and Marketing Reforms

- Enrollment through alliances. Under the current system, health plans can influence the composition of their enrollment through their marketing activities.

Marketing efforts can be focused away from areas with higher-risk populations and agents can discourage applications from higher risk individuals.

Under the Health Security Act, enrollment will occur through health alliances, providing all applicants with an equal choice of all health plans. Consumer information about costs, quality and plan design will be provided directly to individuals through alliances and employers, so the opportunity for selective marketing by insurers will be eliminated. The Health Security Act also requires that direct marketing be made to the entire area served by a health plan.

- Satisfaction and disenrollment surveys. One potential means of risk selection by health plans in a reformed system is to discourage higher-risk enrollees from continuing with the health plan by giving them poor service or failing to contract with providers that can address special needs.

Under the Health Security Act, enrollees can be periodically surveyed to detect problems with health plan service. People who switch plans can be surveyed to determine if they left their former plan because of poor service or inadequate access to specialists. Problems uncovered can be addressed through the state certification process.

#### Insurance Reform

- Guaranteed acceptance for coverage. In the current market, insurers use medical underwriting and a host of other strategies to discourage enrollment by higher-risk people.

Under the Health Security Act, all health plans will be required to accept any enrollee who applies for coverage. Plans will not be able to discourage enrollment based on health status.

- Community rating and guaranteed renewability. In the current market, insurers can directly affect enrollment of higher-risk individuals by raising premiums or terminating coverage for groups with high claims costs.

Under the Health Security Act, an individual's health status cannot be considered in establishing premiums. Coverage cannot be canceled by a health plan for any reason.

#### Health Plan Contracting Requirements

- Contracts with academic health centers. Even with enrollment, marketing and insurance reforms, one potential source of risk selection by health plans is their decisions about which health care providers to contract with. Concerns have been raised that health plans avoid contracting with leading treatment centers and specialists in order to avoid the costs of treating serious health conditions.

The Health Security Act, however, requires health plans to contract with academic health centers for the treatment of health conditions that require the specialized treatment expertise of these centers. This requirement will assure that enrollees who need special services will be able to select and stay in any plan serving their area and receive the services they need.

### Risk Adjustment and Reinsurance Methodology

The Health Security Act requires the National Health Board to develop a risk adjustment and reinsurance methodology to be used by regional alliances. The methodology will assure that payments to health plans reflect expected utilization of services and protect health plans that enroll a disproportionate share of higher-risk people.

The Act directs the Board to consider a number of factors in developing the methodology, including demographic characteristics, health status, geographic residence, socio-economic status and the proportion of cash-assistance recipients enrolled by a plan.

- Adjustment for demographic characteristics and residence. The Health Security Act provides for community rating by health plans. To protect health plans from adverse selection if they disproportionately attract enrollees who are older or who reside in higher cost areas in an alliance, the premium payments by regional alliances to health plans will be adjusted to reflect the demographic characteristics and areas of residence of each plan's enrollees to reflect appropriate differences in costs of care.
- Adjustments for socio-economic status and proportion of cash assistance recipients. The Health Security Act requires the Board to consider the need for premium adjustments to reflect any additional risk that health plans may face by enrolling a disproportionate share of lower-income or cash assistance recipients. Concerns have been raised about the willingness of health plans to serve traditionally underserved people and about the potentially higher administrative and other costs of providing services in underserved areas. If necessary, payments to health plans that serve underserved areas will be adjusted to reflect any higher costs incurred.
- Health status adjustments. The Health Security Act requires the Board to consider enrollee health status in developing the risk adjustment and reinsurance system. Even in a reformed system, there is concern that some health plans may face systematic adverse selection which could affect their ability to compete on price and quality.

The Health Security Act provides for several methods of protecting health plans from adverse selection by higher-cost enrollees. The Act anticipates a short-term and a medium-term strategy. In the short-term (one to three years), we expect the Board to rely on mandatory reinsurance. It may also use health status adjustments based on self-reported health status collected through surveys of plan enrollees. Over the medium-term (three to seven years), we expect the Board to develop and implement more sophisticated adjusters for health status based on diagnosis of enrollees and additional measures that may be clinically based, or other measures.

In the short-term, reinsurance will be used to protect health plans that attract a disproportionate share of enrollees with high-cost or chronic illnesses. Reinsurance systems are being used in a number of states today as part of insurance reform efforts.

Under a reinsurance approach, health plans share the costs of treating higher-cost or chronically ill enrollees. If a health plan has a high-cost claim or

enrollee, the reinsurance system reimburses a portion of a health plan's payments for these cases. This reimbursement can be based on a percentage of a plan's actual costs, or can be a specific amount based on condition or treatment. The health plan pays a premium to the reinsurance fund for this protection.

The Board may develop adjusters for perceived health status or the presence of chronic conditions in the short-term through the use of health status surveys. This approach relies in health status data collected from health plan enrollees, either at time of enrollment or through surveys of random samples of plan enrollees. Premiums would be adjusted to reflect the differences in health status across plan enrollment.

In the next few years, more sophisticated risk adjusters should be available that are based on the diagnoses of individual enrollees. Initial research indicates that these adjusters should be more accurate than other approaches, but no system has been fully developed and implemented that relies on these potentially more accurate measures of risk.

Over the last few years, the Department of Health and Human Services has sponsored and conducted a substantial amount of research looking at the development of risk adjusters for health status, primarily related to special populations (for example, Medicare) or settings of care (for example, ambulatory care and hospitals). To accelerate development of risk adjustment methodologies for the under-65 population, the Department is currently developing a work plan that encourages research efforts in this area. The work plan will call for internal research efforts and for sponsoring research and demonstrations by outside experts.

#### Conclusion

The Health Security Act uses a variety of strategies to address the risk selection problems that plague the existing insurance market. We believe that these strategies will encourage competition among health plans on the bases of price, quality and service.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. As we enter into this experiment and the President's plan wants to affect one-seventh of our economy, having spent the last three Congresses out of the last four on the Budget Committee and becoming somewhat familiar with our attempts to evaluate the economy and the government's receipt of revenues in that economy and the government's spend-out in that economy and our track record of being accurate on assessing the fiscal situation, it gives me great concern that as you presented your testimony, it is, in my opinion, filled with too many words like the methodology will assure, we expect the Board to rely on, a lot of, in the next few years more sophisticated risk adjusters should be available.

It makes me personally very nervous going into this grand experiment with as much hope about the future with not nearly as much specific explanation of our current methodology, how successful we are and the degree to which we can confidently say that on day one we will have in place a mechanism which can do this most fundamental of adjustments.

Can you give me more encouraging statements, Dr. Thorpe, than we hope that, or we think that, in the future we may be able to accomplish these tasks?

Mr. THORPE. Sure, Mr. Thomas. Two comments. First is that as we are all aware, the precise methodology is to be determined by the Board. What I would say, however, is that we believe that our current method of making adjusters—demographic adjusters, a mandatory reinsurance pool and perhaps using self-reported health status measures—is adequate to provide risk adjustments in the market if we had to go with it today, day one.

Mr. THOMAS. Let's take California as an example. How many alliances are there going to be in California?

Mr. THORPE. That would be determined by the State of California.

Mr. THOMAS. We don't know that. At what level are we going to be gathering information prior to our creation of these alliances so that we can have some comfort on the substate level of the information needed to make the adjustments on risk?

Mr. THORPE. Much of the information we already have, certainly the demographic information we currently have.

Mr. THOMAS. And you feel comfortable that you can break it down on the substate level and have equal and adequate information on the various substate levels, county level, or combined county or metropolitan statistical areas? You feel very comfortable about it?

Mr. THORPE. I believe that the census data of those areas are quite adequate.

Mr. THOMAS. OK. What are the fallbacks if you aren't able to do it as adequately as you indicate on day one? Let's assume that the National Health Board puts out an initial cost, which they have got to do, which is a risk adjustment in itself, and are you going to have periodic monitoring so that, short of the 1-year period, you are going to be able to determine how accurate or inaccurate you are?

Mr. THORPE. Again, Mr. Thomas, the adjustment methodology is completed within the alliance, so what we are doing with this and proposing to do is simply—

Mr. THOMAS. Do you agree that the initial setting of the price is in part an adjustment itself?

Mr. THORPE. Well, each alliance will have a premium cap that is set by the National Board.

Mr. THOMAS. And what are the factors used in determining that premium cap?

Mr. THORPE. It would include things such as the cost of providing medical care services in the alliance area.

Mr. THOMAS. What is that determined by, the makeup of the population?

Mr. THORPE. No, we are thinking more about input prices here, what the costs—the medical care costs of providing hospital care, physician care, so on, the input price. They are input price indices and not demographically based.

Mr. THOMAS. When is the adjustment going to be made on the basis of what pools are selected by which approved health plans within which alliances?

Mr. THORPE. One approach to this would be that the adjustments would be made post-enrollment, so depending on the demographics of individuals that actually enroll in different plans, there would be an adjustment in payments to health plans based on who actually enrolls in those plans.

Mr. THOMAS. Since the National Board under the President's plan approves a State plan in the first place, do you envision the examination of the creation of the alliances as part of the structure of determining risk adjustment? That is to say from day one, do you examine the way in which the alliances are put together as part of the risk adjustment mechanism, or will you wait until afterward to determine whether or not they did a reasonably good job?

Mr. THORPE. Again, there are certain rules that have been set out in the legislation or will be set out in the legislation which provide guidance to States about how they can set up alliances. They can segment them as is, for example.

Mr. THOMAS. Finally, I can't find it in the legislation and there was some surprise by some witnesses in a previous hearing and so I will ask you, do you believe that the President's plan, in terms of creating of alliances, anticipates or requires that alliances be contiguous or that is it possible for a State to create alliances that are noncontiguous within the State boundary?

Mr. CLAXTON. If what you mean is that every area would have to be in an alliance—

Mr. THOMAS. No, not that the alliances cover the whole State, but that, say, California has four alliances, but that each alliance isn't necessarily totally contiguous. That is, you can have an alliance, one which represents basically suburban areas and it could be in northern California and in southern California. It would be separated by alliance two, which would principally be a central rural alliance separated by alliance three, which is LA County.

Mr. CLAXTON. The anticipation is that they would be contiguous.



Mr. THOMAS. The legislation does not require it? Had anybody considered that inside the war room when you were putting the President's plan together?

Mr. CLAXTON. I think if you look at the general structure which talks about not subdividing MSAs and allowing for consolidated MSAs to be, it is looking at areas as a whole, not the notion that there would be little pieces here and there that would be an alliance, so no one anticipated—

Mr. THOMAS. I appreciate it, but it doesn't say you can't. So no one anticipated it.

Mr. CLAXTON. We didn't anticipate looking at it the way you are looking at it. We anticipated they would be contiguous, yes.

Mr. THOMAS. But clearly you agree with me the legislation doesn't say it has to be.

Mr. CLAXTON. I actually don't know, but—

Mr. THOMAS. You don't know what is in the President's plan?

Mr. CLAXTON. I will take your word for it that it is not there. I have never read that it is in there. I don't think anyone anticipated that particular development, and I am sure we would be happy to address it.

Mr. THOMAS. No one anticipated that particular event. Do you know what the structure of the California HIPC is, the voluntary HIPC in California? Have you looked at California's structure for its voluntary HIPC?

Mr. CLAXTON. I have not.

Mr. THOMAS. You will find, interestingly enough, that the regions are noncontiguous.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Dr. Thorpe, do you have any data that breaks out the current 37 million uninsured population, if that is indeed an accurate figure? What percent of those are uninsurable; have the preexisting conditions that would essentially be red lined out of the system right now? How many are we talking about, what number?

Mr. THORPE. I don't have the figures in front of me, but I believe that through the surveys we have, particularly the National Medical Expenditure Survey, that we could do a cut at looking at how many of those individuals are uninsurable.

Mr. GRANDY. Well, it would be a small percentage, would it not? I mean if you actually isolate the number of people that because of a preexisting condition or some kind of unforeseen health event, or I should say sickness, are actually unable to acquire insurance right now.

Mr. THORPE. I think, Mr. Grandy, there are two ways of looking at this issue. The first issue is how many people just, if they went to several insurance companies, could never find insurance, and I believe that that is the—

Mr. GRANDY. Or would be unable to transfer jobs, because obviously the job lock question is one that we are all concerned about.

Mr. THORPE. That is one piece. I think a more common element of this, however, is the fact that when individuals who do insure have large medical expenses that are insured suddenly find in the health insurance market their premiums rising at such a rate that

they no longer find it affordable. This de facto makes them uninsurable, even though they can, "have health insurance" that is a more substantial group of individuals.

Mr. GRANDY. Explain that again. In other words, these are people that have insurance now, but something happens to them and they are unable to pay the increase—

Mr. THORPE. The increased premium.

Mr. GRANDY. Because of the claim, a low birth weight baby would be an example.

Mr. THORPE. Exactly. The issue here is really organizing insurance around small groups and individuals. Those individuals and small groups are at daily risk that their health insurance premiums can be adjusted at almost any time if anybody within the group actually has a very substantial medical expense. That is a much larger group of individuals that de facto could be, "uninsurable" because they can't afford health insurance coverage when they become ill.

Mr. GRANDY. And really is it not true that for just about every plan, every one that I have seen or paid much attention to, by disallowing and making illegal adverse selection and guaranteeing issue, we would address that problem head on; is that correct?

Mr. THORPE. That is certainly a necessary, though perhaps not sufficient, condition to make the change begin.

Mr. GRANDY. If we require community rating of course, that would mean you put these people into the pool and the rates for everyone else would at least go up, unless you make the pool large enough so that you spread that risk over a larger group.

Isn't that really the concept behind the health alliance, the 5,000 threshold so you have large enough pools to spread risk?

Mr. THORPE. No. I think that is—if you had a voluntary community rating pool, that the average expense would rise, I think that is correct. We have mandatory pools in a sense, everybody has insurance, so—

Mr. GRANDY. But let me ask you about everybody having insurance. As I read the Clinton plan, there seems to be an implicit individual mandate, and yet if I am a young healthy person and I have decided under the old system that I didn't need health insurance because I was going to live forever and I am young and virile and I would rather have a Porsche than a policy, isn't it true that if something happens to me and I show up at a hospital, I am covered under the plan, but my employer or the plan will pay that expense, isn't it true?

I mean, in other words, they would basically be on the hook for that event; isn't that correct?

Mr. THORPE. Under the President's plan?

Mr. GRANDY. Yes.

Mr. THORPE. No. Under the President's plan, everybody would have health insurance. If in your example the individual had not been making contributions for health insurance prior to the event, then upon enrollment, we do have outlined civil monetary penalties that would collect premiums, I believe, at two times the level that they would have owed had they paid the premium.

Mr. GRANDY. So there is an incentive for someone to get into the system; is that what you are saying?

Mr. THORPE. I would think there is not only an incentive, but there is a tremendous desire, given the premium structure and the payment structure that we set up, that all individuals would want to have the coverage that is provided.

Mr. GRANDY. So, in other words you are not, at least in your view, giving a free ride to people who are healthy until they get sick, and covering the first traumatic event, and then saying they are covered?

Mr. THORPE. That is correct.

Mr. GRANDY. In other words, there is a consequence for not making payments to the plan; is that correct?

Mr. THORPE. There is a consequence of not making payments to the plan.

Mr. GRANDY. All right. Now, under the present system that we have right now, to what extent, and I guess I read somewhere that the self-insurance market covers, I think it is as much as 60 percent of the employment market from between I think 1,000 employees and above.

I would think that market would significantly diminish under the President's plan. To what extent have you got data that confirms that self-insurers are guilty of cherry-picking and adversely selecting and creating the kind of risk imbalance that we are all trying to correct? Is there any data out there that says self-insured plans are a way around providing comprehensive health care or at least underfunded or actuarially unsound health care?

Mr. THORPE. There are several articles and studies that have looked at the fragmentation of what used to be an historic community pool that we had in the 1940s and 1950s and that over time, as individuals and companies thought somehow that through negotiations with health plans they could get a better deal than the average, the whole community rated pool system fragmented and dissolved and developed essentially the system that we have today where health plans and companies try to negotiate with each other based on favorable rates.

Mr. GRANDY. But you can't say really, can you, with that big a share of the market, that people are just self-insuring to get around their responsibilities. You wouldn't go that far, would you?

Mr. THORPE. I think there are several perceived advantages to self-insuring. A piece of it, I think, if you have asked individuals over time why they have self-insured as opposed to paying community-rated premiums, a substantial piece of it is due to the perception that they could get a better deal.

In reality, if you look at the data that exists on the year-to-year growth, for example, and what self-insured companies actually pay relative to what is paid in the insurance market, that perception has not actually paid off in lower increases in payments, but I think the perception has always been there that everybody thinks, for whatever reason, that they are lower cost than the average.

Mr. GRANDY. But can you affirmatively say that the self-insurance community has more effectively contained the growth of health care costs than fully insured plans or government plans?

Mr. THORPE. No. I think the evidence is mixed. And most the of the studies I have seen on this show that the growth on what self-

insureds pay, their premium equivalence is similar to what you see in the insurance market.

Mr. GRANDY. My time has expired, Mr. Chairman, but I would like to ask these witnesses another question on the next go around.

Thank you, gentlemen.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. No questions, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. I am sorry I came in late and missed your testimony, but I have looked over some of it, and there is one thing that just springs to mind, maybe you can clear this up for me. It seems to me that in these regional alliances part of the advantage is having collective bargaining power with insurers or providers to give a service at a reasonable cost, but some of that depends on how many providers or insurers come into that regional alliance and make a bid, so to speak, and some of the alliances are going to be identified, I would think, by insurers or providers as being high-risk alliances. So you could have a situation in a given alliance where you don't have very many providers or insurers coming in to bid for that alliance's business.

Have you foreseen that problem? Are there any things in the President's plan to prevent that from occurring and make sure there is competition in these alliances?

Mr. THORPE. Sure. I think, again, as the methodology in the President's plan reads, that the National Board would determine the premium for the comprehensive set of benefits and would make adjustments across alliance areas for differences in the costs of providing medical care. So to the extent that you do have variation across alliances and the cost of providing medical care services, there would be different premium targets, if you will, in each of those alliance areas.

So there will be adjustments made to reflect the costs of providing medical care services across different alliances.

Mr. MCCRERY. So are you telling me that in these high-risk alliances the premium is going to be a lot higher than they will be in other alliances?

Mr. THORPE. To the extent that the costs of providing medical care services in those areas are different or higher than the cost of providing medical care services in other alliances, then those differences would be reflected in different premium targets, premium caps.

I mean, that is exactly as—again, you see these variations in the cost of providing medical care today in areas that have high-risk populations and some of that variation would be reflected in the premium targets.

Mr. MCCRERY. Some of the variation?

Mr. THORPE. I said some deliberately because the intent over time is that the National Board—an advisory panel would make recommendations to the Board—would set the premium targets to assure that the premium targets don't reflect variations in practice patterns across areas that don't seem to correlate very well with health outcomes.

Mr. MCCRERY. But it seems to me that you are going to be almost punishing the high-risk alliances or alliances that have a

number of people identified as high risk in terms of their insurance or their health care needs, and if you allow the insurance companies or providers to exact a higher price for the same services that are going to be provided everywhere else in the country in every other alliance, it seems like you are punishing the people in that alliance who may not be in many cases the most able to pay higher premiums.

So is there nothing to spread this risk more evenly? I mean, is that what we have been talking about here today, finding some risk adjustment to spread that risk more evenly across all alliances? If so, what is it going to be?

Mr. THORPE. Mr. McCrery, I think that maybe one way to think about this is that the premium caps are going to be set at different rates in different alliances. Those different targets would reflect differences in the underlying costs of providing medical care services.

So to the extent that there is a high-risk area that does have a higher cost providing medical care services relative to a lower risk area, then there would be a different premium target set for those two alliance areas.

The risk adjustment methodologies that we have been talking about would then make adjustments in the, if you will, risk within the alliance area. So you can almost think of this as the two-step process.

The first step is that there would be adjustments in the premium caps for each alliance depending upon the cost of providing medical care in the alliance and the second set of adjusters that we have talked a little bit about this morning so far would adjust for the risk of patients that actually enroll in different health plans within an alliance.

Mr. MCCRERY. Within an alliance.

Thank you, Mr. Chairman. I will listen with interest to the rest of the testimony.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

To followup on some points that were raised earlier, from your responses to Mr. McCrery's comments, Dr. Thorpe, it is clear that if you live in Washington, D.C. and the President's plan is passed, you would be wise to move to the suburbs because your health premium is going to be higher in the D.C., alliance than it is in outlying suburbs, because while you will have the ability to adjust risk between plans within the D.C. alliance area, you don't have the capability to adjust risk between alliances; is that not correct?

Mr. THORPE. Since the alliance areas haven't been drawn, I can't specifically address it, but let me just simply say that the cost of receiving medical care services in Washington are more expensive today than they are receiving it in Fredericksburg.

I mean, those differences exist in today's market and depending upon how alliances are structured, they would exist to a certain extent after the President's plan is adopted.

Mrs. JOHNSON. So really the only way a State could avoid those problems is to have a single State-wide health alliance, and then they may still have those problems where they have border cities,

cities that are in their State, but the suburbs are in the surrounding States.

So you do run the risk with this plan of driving population shifts, but more importantly, driving employers' siting decisions, employers' location decisions?

Mr. THORPE. Again, I don't think that the plan that we have on the table does anything at all to increase the variance in underlying medical care costs. In fact I think that what you will see, it will reduce the variation across areas in the cost of providing medical care services.

Mrs. JOHNSON. I would certainly agree with you in that statement, but in terms of who pays for those costs and how that cost is distributed across payers, it certainly does change that, and if alliances are defined by metropolitan statistical districts, which you recommend in one part of your plan, within those districts the costs will be higher because that is where the highest cost population is.

So I find it very hard not to go along with the concern that the higher premium, just like higher property taxes in our cities, drives not only individual homeowners out, but discourages businesses from locating in those areas, and it will be one more disincentive to locate in cities.

I want to go back to——

Mr. CLAXTON. Ms. Johnson, if I could just make one point about that. One of the reasons that people look at cities as being higher costs is that there are a lot of uninsured people and there are a lot of nonworkers there.

We are going to be providing everyone insurance, and through the discounts that we provide, which are provided federally, we will actually be doing some amount of investment in those areas because the cost of supporting the number of uninsured people and the number of non—the formerly uninsured who are nonworkers will be borne nationally as opposed to by the area itself.

So there is some—probably additional help compared to today's system where D.C. has to bear some of its own costs with respect to the number of uninsured for uncompensated care.

Mrs. JOHNSON. Mr. Claxton, it is my understanding of the administration's plan that the differential between Medicaid reimbursements and private sector reimbursements will be maintained, the disparity.

Mr. CLAXTON. That is right.

Mrs. JOHNSON. So while the government may be participating in the reimbursements for the formerly uninsured, the rate at which they will be participating is very low, and currently while that cost is being shifted to the private sector through the system, a good deal of that cost, unless we are able to reduce it, as your plan assumes, will continue to be shifted to other payers, because the disparity is maintained in your reimbursement structure.

Now, in asking other administration people about this issue, they say that because costs in the overall system will be lowered, the disparity will be decreased, but they do not dispute the fact that Medicaid reimbursements will stay at the current levels or even lower.

Mr. THORPE. Under the President's plan Medicaid will no longer directly contract as a payer with hospitals and physicians because

individuals who are currently on Medicaid will receive health care through the alliance and will be selecting health plans, so in that sense, Medicaid is not addressed.

Mrs. JOHNSON. But the care that will be paid for will be disparate.

Mr. THORPE. The rate at which——

Mrs. JOHNSON. I don't want to take too much time with this because we are always time limited. The second thing is I want to reaffirm your response to my friend, Mr. Grandy.

There is no evidence that the self-insured market is cherry-picking. I mean, I think that is fair to say and from your responses that is fair to say. People choose to be self-insured because they think they have more control over costs, and sometimes they do and sometimes they don't, but also because they are out from under State mandates and if you are in a State with high mandates, you do have more control over costs, but the question I want to ask you——

Mr. CLAXTON. Mrs. Johnson.

Mrs. JOHNSON. Let me go on to the question and we can discuss the other things later. Unfortunately, these sentences are also longer than 5 minutes allows. But the experience with voluntary health alliances in California is very interesting. It is true, it is short, but the key issue seems to be whether the pricing is the same within and without the alliance, and if the prices are the same within and without, then there seems to be no necessity to mandate purchase through the alliance.

So far there is no evidence of risk selection within or without or amongst the HPPCs and consequently it seems to me wise to defer this issue of how to deal with risk shifting and risk selection until the reports of the actuaries come through in January and February, and we can get a better grasp on how we are going to need to do that State-wide if the necessity arises.

Do you have any comments on California's experience with the voluntary purchasing cooperative?

Mr. THORPE. No. I think, Mrs. Johnson, like you, we are still looking at it. I think it does suffer from the fatal flaw that it is voluntary and it does——

Mrs. JOHNSON. But the experience isn't supporting what we thought would be the fatal flaws of voluntary purchasing cooperatives. So I mean I want you to comment on the experience, not on the theory, because the theory is being disproved.

Mr. CLAXTON. Except our experience is 10 to 15 years of just radical risk selection in the insurance marketplace, and I don't think there is any reason to believe that there will be an overnight reform just because of a voluntary alliance.

Mrs. JOHNSON. There are two differences between the 15 years of experience and California's experience. California's experience is in the context of insurance reform and is lacking the right to exclude for preexisting conditions, lacking the right to drop, and so on and so forth.

And second, it is in the context of a public policy that prohibits price differentials for the same product inside and outside. So I think we are going to have to be much sharper than that, Mr. Claxton, if I may, than to draw generalities from past experience

and apply them to the context in which experience is legally and materially different.

Mr. CLAXTON. Well, even in your own State, you have had some experience with market reforms where, while it is illegal to use preexisting conditions or not to accept certain groups into the small group market, you know the kinds of experience they had with new rating factors being put in place for group size.

Mrs. JOHNSON. Because we did not require two things, we did not allow the basic plan to override State mandates, and we did not require the same price for exactly the same product.

All of these new proposals have an identical basic plan that is offered, and so the circumstances—we didn't go far enough in Connecticut, so you are right, we didn't eliminate all risk selection.

Mr. CLAXTON. I think all of those are true, but there are elements in California that are open to the same problems that you had in California—I mean in Connecticut, that maybe they will address eventually, having to do with how you compensate people for providing coverage, how you make sure that insurers are marketing fairly in every area.

I worked on this for some number of years, writing first a model act, then model regulations for the NAIC, and then a compliance manual, and at every point there was always some other element of risk selection or some other problem with making people deal with getting insurance to people they don't want to insure.

Mrs. JOHNSON. Right. And the key element is getting the group so large that that doesn't matter, and there are some new studies now that show if we reorganize the market under 100 employees, we reach that level of largeness and that there is no necessity to reorganize the entire purchasing market as the present proposal does.

My time is expired, and I know it is frustrating to you to be cut off and my getting the last word, but I assure you I haven't gotten the last word. This is a long discussion and I look forward to working on it with you.

Chairman STARK. I will stipulate to that. Mr. Claxton, I heard you say that you thought in the District of Columbia by in effect guaranteeing coverage to almost whatever we have, 200,000 people without coverage or access, we would thereby, I presume, lower the disproportionate share and other costs, and the costs in general would be lower or controlled in the District.

Was that your answer to Mrs. Johnson a moment ago?

Mr. CLAXTON. My point was that some of the burden of dealing with the cost of uninsured people is borne federally and nationally because the subsidy payments that come in are from the Federal Government.

Mr. THORPE. As a followup, I think it is fair to say that the price of private health insurance is higher in the District than it otherwise would have been.

Chairman STARK. Mr. Claxton, do you have any studies that show anything on that in any cities? Do you have some data on that? I mean, you are suggesting that we are going to save money in areas like the District of Columbia relative say to suburban Maryland when we insure everybody.

Do you have any studies or any data to that effect?



Mr. THORPE. Certainly if you look at—

Chairman STARK. Either you have got some studies or you don't.

Mr. THORPE. We do have data looking at what State and localities would save as you provide universal insurance.

Chairman STARK. But for specific cities. Do you have studies like that relative—that you have done recently?

Mr. THORPE. We have actually looked at a specific study for the City of New York.

Chairman STARK. I beg your pardon?

Mr. THORPE. We have looked at the City of New York as an example.

Chairman STARK. But nothing you have done in-house or had done for you at HCFA or for the—

Mr. THORPE. Actually it is being done in-house right now, yes.

Chairman STARK. But it isn't complete?

Mr. THORPE. It is not complete. It is looking at changes.

Chairman STARK. So this is an anticipatory statement on Mr. Claxton's part of what he thinks the study will show; is that right? I am asking Mr. Claxton. He answered Mrs. Johnson.

Mr. CLAXTON. I think it is a fair point to say that in areas where there is a lot of uninsurance and where there is significant uncompensated care, that the health costs are borne disproportionately by the people in the area because they are paying the insurance premiums in that area.

Chairman STARK. I think Mrs. Johnson's question is whether what do we do for the difference in the District of Columbia and somehow your answer implied to me that we would balance that out.

Mr. CLAXTON. I didn't say we would balance it out, excuse me, Mr. Chairman. What I did try to say is there was some amount of advantage because the discounts that are provided for people who are now nonworking, and who are a disproportionate burden on the areas they live in, are being provided federally, and so there is a certain amount of cross subsidies in that area.

I did not say that it completely compensated for it.

Chairman STARK. You never considered that it might cost more to provide care to those who are now not getting any care at all when you have perhaps a third of the population uninsured. That ever show up on your screen?

Mr. CLAXTON. I think that it probably does cost more to provide them care. I do not think—

Chairman STARK. In the aggregate. The total costs for the District of Columbia might increase?

Mr. CLAXTON. That is a fair statement. But it is also true that there will be more payments into the District as well. It will not all be borne by the current people paying premiums.

Chairman STARK. But then it will be a higher cost relative to, say, Fairfax?

Mr. CLAXTON. Except more people will be insured. So I guess the issue is what is the average premium that it costs to support those costs.

Chairman STARK. You have studies to show it might be equal or lower? You have got an average cost now in the District of Columbia, whatever it may be, and you are going to tell me that if we

provide access and coverage to every resident in the District of Columbia, it is going to lower the average costs in the District of Columbia; is that your statement, Mr. Claxton?

I am trying to—these answers come out of you guys pretty quickly here, and I would like to know if you are making them up as you go along, or if you have got some studies you are not sharing with us.

Mr. THORPE. May I?

Chairman STARK. I would hear from Mr. Claxton, Mr. Thorpe, and then I will get to you.

Mr. CLAXTON. My statement was that currently people who are paying insurance premiums now are paying higher premiums to cover uncompensated care cost.

Chairman STARK. Right. We know that. We all know that. Sun comes up in the east, OK.

Mr. CLAXTON. We are saying that was disproportionately borne by the people in the area where those uncompensated care costs occur.

Chairman STARK. And no inference therefore that by covering everybody in the District, we would somehow lower the cost or lower the average cost.

Mr. CLAXTON. We should lower the amount of—we should lower the cost of those payers now because they are no longer supporting the uncompensated care costs. There will be other payers in the system. To the extent that—

Chairman STARK. As I recall in the President's plan, we are going to add to the cost of the other people in the District of Columbia, or those employers who are going to be paying, to cover these subsidies you are talking about.

Mr. CLAXTON. Employers who are paying nothing now will pay more, but also the government will put in money to the extent the people are underemployed or unemployed.

Chairman STARK. Up to a cap?

Mr. CLAXTON. Yes.

Chairman STARK. But if it exceeds that cap, then the people in the District of Columbia will pay more; is that correct?

Mr. CLAXTON. I don't believe that is correct.

Chairman STARK. You don't. Where do you think the money is going to come from?

Mr. CLAXTON. I believe that to the extent the money that is provided in the entitlement caps is insufficient, that the President needs to make a recommendation to Congress to try and bring spending and funding in balance.

Chairman STARK. And if that doesn't happen?

Mr. CLAXTON. If that doesn't happen, then the alliances have insufficient money.

Chairman STARK. Would you like the litany of—I mean in this room for 20 years, we have underfunded the District of Columbia for police, for fire, for schools, for health care, and somehow you think there is something that I missed in those 1,300 pages as to why this Congress is going to vote more money for the District of Columbia?

Mr. CLAXTON. I think I would let Dr. Thorpe answer how our premium estimates came about.

Chairman STARK. I understand. It would be helpful—I mean, we are trying to get at risk selection here and what you guys know or feel is empirical, because that does help us decide.

I tell you, the Chair is biased and it should come as no surprise. I do not believe, and I am hoping that Dr. Thorpe will enlighten me otherwise, that there is any treatise, paper, learned article, unlearned article, anything written by Evans and Novak, Rush Limbaugh, Ross Perot, that suggests that there is a risk selection program available.

I have just watched my prejudice here. I don't want to pretend that I am neutral on this issue. I don't think it can be done.

Mr. THOMAS. It came through, Mr. Chairman.

Chairman STARK. And I don't think that Mr. Thorpe, if he were defending his academic reputation, could do that, but I am going to give him a chance in a minute. It doesn't seem to me that is a fatal flaw, but it is one of these problems like not calling mandatory employer contributions a tax. I don't really care.

I mean, I think mandatory participation is essential to the plan and important, but why we have to run around the barn and stand on our head to avoid calling a tax a tax, escapes me because Mr. Thomas is going to call it a tax, and he is going to whisper in the ear of my opponent that it is a tax, so now we get to—let's get to risk adjustment and whether it exists or doesn't exist, and the first thing that I would like to talk about a little bit—well, let's just start.

Do you know, Mr. Thorpe, of any current or ancient attempt to describe a risk adjustment plan that is in such a stack that you could take it and make it work. Is there any?

Mr. THORPE. Sure, I believe that—again, let's spend as much time on this if it is OK with the Chair.

Chairman STARK. I just want to know if you can name a study or two.

Mr. THORPE. I would be happy to give it a shot.

Chairman STARK. OK.

Mr. THORPE. I think the first thing that we all have to keep in mind in this is that what we are focused on is trying to predict the health care expenditures of individuals based on observable characteristics.

After all, the issue here is whether or not, when a health plan or an alliance sees somebody, they can do a good job of actually picking you versus you and predicting—

Chairman STARK. Let's stop. That is the second line of questioning. You want to talk about how companies select, OK? We will get to that.

Mr. THORPE. That is the flip side of us doing the risk adjuster: we have to set up—

Chairman STARK. All I am trying to suggest is that let's stipulate that cherry-picking goes on, that risk minimization is an art form among insurance companies, and I will, for every regulation you have got that tells me you are going to stop it, I have got three more plans that I am getting from insurance companies as to how to get around it, and that is like tax loopholes.

It is a never ending, ever reducing radius of concentric circles. When we get to risk adjustment, is there any data or any study

or any theses or any articles that you know that come close to outlining a plan of risk adjustment that can be used in the President's plan? That is all I want to know.

Mr. THORPE. Yes, again, if you look at the amount of predictable variation in health care spending that we have to deal with, it is quite low. It may be 20 percent of the actual variation of a group.

Chairman STARK. We are going to hear differently in a moment, 30 to 50 percent from the actuaries, but go ahead.

Mr. THORPE. That of that we believe that the existing methodologies that we have today, demographic adjusters and mandatory reinsurance program, as well as all the structural changes we have made, it is not just the demographic adjusters, it is not just the mandatory reinsurance.

I went through a litany of structural changes in the market that we are going to make.

Chairman STARK. But you don't have an outline of that. Nobody has written it any place or thought it through, except Ira, right?

Mr. THORPE. No. I believe that, again, I would be happy to try to pull together as many articles along that line as I can. They all do suggest that in order to minimize risk selection, that the types of changes the President's plan has proposed are a precondition of those. We have all of those in the proposal.

In addition, we have the reinsurance pool, the demographic adjusters, and using self-reported health status, which we know correlates quite highly with actual health care use. And there are several articles that hold true how high the correlation is, and I will be happy to provide the committee with this data.

Chairman STARK. Mr. Lubitz.

Mr. LUBITZ. Yes.

Chairman STARK. You are familiar with the concept of risk adjustment?

Mr. LUBITZ. Yes, I am.

Chairman STARK. And it has been a matter of concern for HCFA for at least 10 years to risk adjust for the risk contract that goes on in Medicare, is it not?

Mr. LUBITZ. That is correct.

Chairman STARK. And you have been heading up the effort to find a risk adjustment or a risk anticipation plan for risk contracting under Medicare, have you not?

Mr. LUBITZ. I have been working on that, yes.

Chairman STARK. How many people have been working with you on that for 10 years or more?

Mr. LUBITZ. I would say on and off about five people.

Chairman STARK. And how close are you to having a system that will help us be confident that we are not paying too much in the risk plans under Medicare?

Mr. LUBITZ. I think we could reasonably say that for Medicare, we could have a system in place.

Chairman STARK. When?

Mr. LUBITZ. In a fairly short time.

Chairman STARK. Why haven't you ever brought it up to us? Do you like wasting money?

Mr. LUBITZ. I don't like wasting money, but it has not been my role to make policy. It has been a policy call on whether or when to implement a risk adjustment.

Chairman STARK. So you are telling me you think I have a plan now to risk adjust under the Medicare contracts?

Mr. LUBITZ. I think we could risk adjust Medicare contracts within a reasonable time, yes.

Chairman STARK. How many years is that?

Mr. LUBITZ. I would hate to be quoted on it, but I would almost say within 1 to 2 years.

Chairman STARK. I would like very much to see it. As I say, you are hiding your light under a bushel, Mr. Lubitz. I know some people in other parts of town that might pay dearly. Are you at the top of the executive pay grade scale yet?

Mr. LUBITZ. No.

Chairman STARK. Well, I would hold out. I sure as hell wouldn't come forth with that plan until I got up there because nobody else in the government has it. I am curious—we have to vote in a minute, but you indicated, Dr. Thorpe, that you are going to turn this problem of risk adjustment over to the national Board to come up with a plan; is that correct?

Mr. THORPE. The National Board would be responsible for developing the methodology that alliances would use.

Chairman STARK. How many people that you plan or—how many people have you suggested to the administration you will have on the staff of the National Board working in the first couple of years in the area of risk adjustment?

Mr. THORPE. Well, most of the research is—as Jim Lubitz has mentioned, we have a substantial research program ongoing within the department.

Chairman STARK. But how many people did you suggest to the administration would be necessary working for this National Board to work on the area of risk adjustment?

Mr. THORPE. I personally haven't made any specific recommendations.

Chairman STARK. If I said two, would you care to dispute me?

Mr. THORPE. No. I think it is fair to say that the research activities would be contracted out and would be conducted primarily by the department and by outside experts and that it would be overseen—

Chairman STARK. It assumes in your plan that there would be a 15 member risk adjustment technical advisory committee that would meet two times a year for 4 days and that you would have two for the first 2 years, and then ongoing you might have as many as 21, but one presumes that for 2 years, two people are going to do this?

Mr. THORPE. Certainly in terms of specific meeting schedule, I can't comment. The research would be done through the department and through its outside vendors and contractors, and the results would have to be presented to the Board. They would be periodically.

Chairman STARK. Was that presented when you printed the outline of what resources were needed for the implementation of the National Board?

Mr. THORPE. I believe that it was clearly considered that many of the basic research functions would be conducted outside of the Board.

Chairman STARK. I would like a copy of it. I can't find it. If you can find for me anything, other than this risk adjustment technical advisory committee and GS 13's, it ain't worth it, Mr. Lubitz, a 14-member—we can do better for you over here.

I guess I am suggesting that what one hand is testifying to us on, the other hand is not intending to perform on, and when Mr. Lubitz has had five people working for 10 years to come up with some kind of risk adjustment, the idea of having two people for a couple of years to get this going, sounds to me sort of like how we were going to sell cold fusion. Now, we will get back to that.

We are going to recess for 10 minutes while we all make this vote and we will continue.

[Recess.]

Chairman STARK. Thank you, if our guests will find seats, we will continue. I first of all wanted to excuse Mr. Lubitz. It is my understanding that it was not Mr. Lubitz who was hiding the risk adjustment plan. It was to be presented to us at Mr. Bush's second inaugural address, and that it was not intentionally being hidden by the previous administration that there was——

Mr. GRANDY. Mr. Chairman, we meant it as a gift to the committee.

Chairman STARK. Well, I suppose we will hear from people as the testimony goes on today about what risk selection can do and cannot do. I would like to now look at the reverse side of the issue, Dr. Thorpe, that you brought up, and that is we recognize that there is an incentive for plans—let's put a happy face on it, to select the healthiest people.

Something like half the people who are insured every year costs nothing, I think. So if you are running a health insurance company, the real incentive is to find those people, right, and bring them into your plan and there are ways to do that.

And you said there will be specific regulations that will tend to minimize the effect of aggressive risk selection by the companies. Was that your statement?

Mr. THORPE. [Nodded his head.]

Chairman STARK. Do you intend to in effect prohibit sales people from selling plans directly to individuals or groups?

Mr. THORPE. Yes. The intent is that the marketing and sales will be done through the alliance and that any marketing material that a plan wants to put forth would be approved prior to its release by the alliance.

Chairman STARK. And that includes television, electronic media or anything else?

Mr. THORPE. Yes, any marketing activities.

Chairman STARK. And would there be a limit on the costs of marketing?

Mr. THORPE. No. There would be a natural limit in the sense that the plan is making per capita bids, so in a sense there would be a natural limitation on what they could spend marketing.

Chairman STARK. But no one could work on an incentive or commission that would lead to rewards for selecting risks?

Mr. THORPE. That is correct.

Chairman STARK. Would there be any limitation on designing of the plans, what the benefits are above the minimum benefit?

Mr. THORPE. Yes. The plans—what is included in the benefit package would be standard. If there are supplemental benefits, that is dealt with as a completely separate enterprise.

Chairman STARK. Would a plan be prohibited from offering benefits above the basic benefit package?

Mr. THORPE. As part of the basic bid, yes, they would.

Chairman STARK. They would. Would they be prohibited from offering services free?

Mr. THORPE. The plan itself free or—

Chairman STARK. No, let's suppose that I join the American Super Duper Health Plan in my alliance and American Super Duper offers people arriving in the area—kind of a Welcome Wagon service to its clients. Would that be prohibited?

Mr. THORPE. Yes. That is, again, the contributions from employers and employees—for everybody—would be as is laid out in the plan.

Chairman STARK. Then how about in the additional benefits, would those all be standardized? If a company were offering what we would—you and I would think of as Medigap, there will be supplemental benefits that you will allow to be offered; is that correct?

Mr. THORPE. Yes. I would think there would be a limited market for supplementals because of the breadth of the benefit package.

Chairman STARK. Let's leave that to the results of what is going to happen, but if a supplemental plan were offered, there is no limit to what could be put in that; is that my understanding?

Mr. THORPE. Yes. There is no standardization of the supplementals.

Chairman STARK. Beg your pardon.

Mr. THORPE. There is no standardization of the supplementals.

Chairman STARK. So I am the great American Super Duper Health Plan and I bid on the minimum—or the standard benefit, but then, and only if you sign up with my plan, you qualify for my supplemental plan, right?

Mr. CLAXTON. Tie-ins are prohibited, Mr. Chairman.

Chairman STARK. I beg your pardon?

Mr. CLAXTON. Tie-ins are prohibited, Mr. Chairman.

Chairman STARK. So no tie-ins. In other words, my supplemental plan has to be—

Mr. CLAXTON. Freestanding.

Chairman STARK. Now, are the plans limited in terms of the physicians that may be in a plan? Can a plan limit the number of physicians?

Mr. THORPE. Well, to the extent that they do today, if you have a group model HMO. A plan could as one part of its operation have such a limitation.

Chairman STARK. So you could have a list of doctors and you have got to use those doctors or basically none, right? If you are not in a fee-for-service plan, you take those doctors or none?

Mr. THORPE. Except in the group model example, you also have to have another premium, another plan that would allow for free choice.

Chairman STARK. For a fee-for-service?

Mr. THORPE. Fee-for-service.

Chairman STARK. But not by necessarily the same company?

Mr. THORPE. Every health plan would have to—if you are a group model HMO, for example, you would also have to offer a fee-for-service type plan. You can have a separate premium for it, but it would be a separate plan.

Chairman STARK. So if I am Kaiser Permanente operating in the Bay area, I have got to offer a fee-for-service plan in the same alliance?

Mr. THORPE. You have to offer a point of service option, yes.

Chairman STARK. A point of service option, which means that there are certain doctors or any doctor outside? I mean, I am perfectly willing to agree with you, but what you are saying is that every plan—it was my understanding that every alliance had to offer a fee-for-service plan within a group of plans, but let me just ask that question one more time, that every plan, whether it is Pru or Kaiser or Humana must offer, in addition to a managed sort of plan, a fee-for-service alternative?

Mr. CLAXTON. A point of service, yes.

Chairman STARK. Let's say point of service. When you say point of service, would the point of service providers be restricted?

Mr. CLAXTON. No.

Chairman STARK. So when you say point of service, you are saying an indemnity plan for any provider that I choose with a difference only in co-pay basically; is that what your understanding is?

Mr. CLAXTON. Yes.

Mr. THORPE. Yes. Really there are three models that we have talked about. We have talked about a fee-for-service traditional indemnity style plan, a traditional point of service plan.

Chairman STARK. Now, what is the difference between that in your—Mr. Claxton—

Mr. THORPE. There is a third type of plan which would be traditionally configured as a staff or group model HMO.

Chairman STARK. You understand what that is, that is Kaiser. Now, if I joined Kaiser and I want to go to Stanford or let's say UCLA, in the fee-for-service plan, I can go there, right—

Mr. THORPE. That is correct.

Chairman STARK. —or I can go back to Johns Hopkins?

Mr. THORPE. Yes.

Chairman STARK. What about in the point-of-service plan, what is the difference?

Mr. THORPE. Again, the only difference would likely be in the cost sharing associated with the point-of-service option. What the intent is is to have another option where individuals could have freedom of choice of providers subject to a different cost sharing arrangement.

Chairman STARK. Let me follow through this a minute. One of the cost problems we have among seniors—boy, I hope you guys understand this plan better.

So what you are saying is we have got the Federal employee benefit plan up now, and if I were to join a staffer model HMO and



I would have a premium arguably that would be lower than an indemnity plan, is that what we would anticipate?

But then for a 20 percent co-pay anytime I choose, I can go to any doctor in the country without going through the gate keeper. I just—

Mr. THORPE. It is a separate—the way it is configured is a separate plan and a separate premium and a different cost sharing arrangement. But if you wanted to join that arrangement, you could join it. So that, for example, Kaiser would also offer a point of service option plan as well as its more traditional staff and group model plan.

Chairman STARK. And for the same premium?

Mr. THORPE. No, the premiums could be different. They would be different premiums.

Chairman STARK. Well, that is a topic for another day.

Mr. MCCRERY. Mr. Chairman, may I followup because I am confused?

Chairman STARK. By all means.

Mr. MCCRERY. Are you all saying that every insurer or group of providers that makes a bid to the alliance must make a bid for a managed care situation, a point of service or a fee-for-service?

Mr. THORPE. No, what we have outlined—

Mr. MCCRERY. Options. They must give 23 options or 2 options?

Mr. THORPE. What we have outlined is essentially three cost-sharing arrangements that plans can come in underneath. There is a fee-for-service cost sharing arrangement. There is a point-of-service cost sharing arrangement, and then there is a cost-sharing arrangement for what are generically called HMOs, which is—

Mr. MCCRERY. I know, but say Kaiser Permanente in California wants to bid on the services for the San Francisco alliance, must they provide the alliance, not only with what they are accustomed to doing, which is an HMO, but they must create another plan, point-of-service or fee-for-service plan, and say we are going to offer this also?

Mr. THORPE. Separate plan, separate premium, yes.

Mrs. JOHNSON. Mr. Chairman, may I question on this same issue?

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. In the discussion of this change in the bill, what consideration was given to the capital investment that is necessary to establish a fee-for-service plan as opposed to an HMO?

I mean, they are two different kinds of business entities. They require different capital investments.

Chairman STARK. I am going to suggest, Mrs. Johnson, that I am not sure that this panel are the folks to do that. We were trying to deal with risk adjusting but—

Mrs. JOHNSON. What I am trying to get at is that this isn't just a question of offering three different prices for basically a similar kind of product.

This is from the health alliance having to assure that these different options are available to the individual company.

Chairman STARK. What I think we are talking about here is can this marketing, and I would submit if what I am hearing is the

issue, that it will be difficult to tie in other services or—and I just want to double-check on this.

One of the ways that companies would avoid adverse risk is, for example, they understand that the chronically ill tend to not change providers, OK? They know that because they have been avoiding them. And therefore they would go out of their way and jump through hoops, say in the District of Columbia to leave out Johns Hopkins, Georgetown, and George Washington because they figure that the chronically ill who had been in an indemnity plan would have a provider linked to one of these centers of excellence and a good way to make sure that you don't get the chronically ill is don't include their provider in the system, and I don't know how you can write a law against that, but I think what you are telling me is that there will be enough alternative plans so that people can go to Johns Hopkins or Mayos or any place they want at not a tremendous increase in cost, but then I guess you end up with a tremendous risk selection against the group plans, which is what you have now.

The only reason that managed care saves any money now is that anybody who is sick goes into an indemnity plan and the managed care people by default tend to get the younger, healthier ones, so would you not be exacerbating the current practice, there.

Mr. THORPE. No, the plan lays out that health plans would have to contract with the central community of providers, as well as leading treatment centers and academic health centers. So that is a provision in the proposal.

Chairman STARK. Every leading health center?

Mr. THORPE. Well, leading health centers in the area that they are serving within the alliance.

Chairman STARK. Who would decide what is leading?

Mr. THORPE. That would be left, I believe, to the Secretary to make a determination.

Chairman STARK. So if they decided that Johns Hopkins wasn't in the area of Washington, D.C., you are out of luck, is that what you are telling me?

Mr. THORPE. If the answer to both of those was no, if it wasn't deemed to be a leading provider.

Chairman STARK. Mayo is not in the area, right, if you are in the District of Columbia?

Mr. THORPE. Certainly for specialized treatment it certainly could be; leading provider here could mean that.

Chairman STARK. Austin, Tex.

Mr. THORPE. Presbyterian Hospital is a leading provider of transplant services, and it could be deemed to be.

Chairman STARK. And the Health Board is going to make these decisions as to which plans are going to have which providers or the Secretary?

Mr. THORPE. The Secretary makes a determination.

Chairman STARK. And that will hold for every plan in the area?

Mr. THORPE. Yes.

Chairman STARK. They must offer those services?

Mr. THORPE. Yes. Yes, they must contract with leading treatment centers as well as essential community providers.

Chairman STARK. OK. There is no need for risk adjustment under a single payer system, is there? I know that is not very likely to be the end product, but is it not technically true that if you have a single payer system, you don't need a risk adjustment system?

Mr. THORPE. Only in the sense of how you risk adjust paying hospitals and physicians; you do need a risk adjustment for that. It is similar to what we have in the DRG system, so you do need a risk adjustment methodology.

Chairman STARK. In essence a risk adjustment was far less of a concern in a single payer system?

Mr. THORPE. You don't have to risk adjust for insurance plans, that is correct.

Chairman STARK. Well, I just want to—health plans will only be able to use ads or marketing mechanisms that are cleared by the local alliance or the—

Mr. THORPE. That is correct.

Chairman STARK. —or the Secretary?

Mr. THORPE. No; by the local alliance.

Chairman STARK. And you still intend to allow health plans to select their own geographic location within an alliance and MSA; is that correct? That is still in the bill?

Mr. THORPE. That is still in there, although I should point out that the risk adjustment methodologies are by alliance area, so they have taken into account the risk of individuals in the whole alliance. So money would be redistributed within the alliance as a whole.

Chairman STARK. I am thinking of advertising. If you have got a plan that works out of Georgetown and Sibley, and they decide that is going to be their geographic area, and they aren't going to go into Ward 7 and 8, arguably they might have a different type of advertising, use different television or radio stations than somebody in Wards 2 or 7 and 8.

Are you going to require that all of these ads be the same, all be in Spanish, for instance, or—

Mr. THORPE. In the area where they market, although—yes. What I would like to say though is that States could require, for example, in your example of that plan, to have a broader service area.

Chairman STARK. I didn't read that.

Mr. THORPE. So they could serve—they could have the plans—

Chairman STARK. They may permit plans to geographically select—in banking we call that red lining, Dr. Thorpe, but I know your specialty was health care and not banking, yes. That is all right.

Now, why is it that the department—perhaps Mr. Claxton and Mr. Lubitz have got some institutional memory in this case, chose not to issue the hospital mortality data this year? Do you know that, Mr. Lubitz?

Mr. LUBITZ. I don't know the reason.

Chairman STARK. Dr. Thorpe.

Mr. THORPE. I would have to look into it for you.

Chairman STARK. If I said that there were serious concerns about how accurately the data could distinguish between the qual-

ity of the hospital and the risk of the patient population, and therefore the department chose not to issue the hospital mortality data, would that sound like a reasonable explanation to you?

Mr. THORPE. I think that would be probably more appropriate to ask Mr. Vladeck.

Chairman STARK. If I told you that was the case, let's stipulate that for a moment, don't you suppose it would be at least as hard to develop a risk adjustment system to measure the quality of health plans?

If the department is unwilling to let me know all the bad news about Humana for some reason, and they state that it is a concern of how accurately the data could distinguish between quality of the hospital and the risk of the patient population, if you can't determine that, how do you plan to determine that in the risk adjustment field?

Mr. THORPE. With respect to the first, I can't specifically address it because I think it would be more appropriate to ask Mr. Vladeck the question.

Chairman STARK. Let's assume for the minute that that is the case.

Mr. THORPE. With respect to the risk adjusters, as I mentioned, given the fact that we are looking at trying to adjust for the risk of large groups of individuals selecting into plans, which is what the issue here is, the question is, can we do as good of a job based on observable characteristics of individuals coming into plans as the health plans themselves.

The answer, I believe, given the structural change that I have talked about, as well as the demographic and reinsurance mechanism, as well as the use of perceived health status, I believe that indeed we can, that risk adjustment methodology initially would be quite adequate.

Chairman STARK. I have got a question here to characterize the administrative burden of your risk adjustment system, but it seems to me we have dealt with that in an earlier question about how many people you will have doing it, so that we can go from there.

Well, what would you suggest are the problems, Dr. Thorpe, if we can't risk adjust? I was reviewing some testimony earlier that was delivered to the Congress some years back about cold fusion, and the gentleman representing the University of Utah was extorting Members of Congress as to how stupid they were because they didn't take advantage of cold fusion, which in its economy, its environmental purity, it sounded a lot like perpetual motion, and something that wouldn't cost very much.

Well, there were some of us who, muck wonks that we are, didn't accept it and thought that that might be the last we would hear of cold fusion.

Let's assume that risk adjustment is equally elusive. What happens to the plan if we can't risk adjust well? What are the consequences? Why is this so important? Why are we having a hearing and worrying about this? Why has Mr. Lubitz spent 10 years trying to do it for Medicare?

Mr. THORPE. I think clearly if you didn't do the 9 or 10 structural changes that we proposed, that you would be in the same—we would be in the same boat that we are today, that the entire prac-

tice of health plans would be devoted to try to attract favorable risk.

We would have continued fragmentation in the market that, we would have a lot of churning in the market and red lining, as you talked about it. I think that we would have serious problems. That is why we have come forward with very specific structural changes, if you go back to the first part of my testimony where we outlined what we think are substantial structural changes that go a long way down the road of preventing existing practices of how health plans currently select favorable risk.

I think that even independent of our ability to use demographic adjusters and a reinsurance mechanism, as well as the use of reported health status to do additional risk adjusters, that the structural changes that we have talked about bring us a long way down the road of really taking away from the industry many of the tools that it currently uses to try to attract favorable risk.

I think the costs of not doing these reforms, these structural changes, would be very high and we would be in the same—we would be facing the same set of problems 3, 4, 10 years down the road, even worse than we are now.

Chairman STARK. Mr. Lubitz, you are familiar with all these concerns about risk adjustment. Would you say it has been a serious effort over the last 10 years in HCFA to try and find a solution to risk adjusting?

Mr. LUBITZ. I think it has been a serious effort over the past 10 years, yes. The emphasis has varied from time to time.

Chairman STARK. Secretary to Secretary, yes, I understand that, but it has been a concern, anti-moment, there is an actuarial group that has been working on it I understand. Is it fair to say at this moment there is no specific plan as we sit here today.

Mr. LUBITZ. For Medicare?

Chairman STARK. Yes, to risk adjust.

Mr. LUBITZ. That is correct.

Chairman STARK. And I guess I would just ask Dr. Thorpe, is there a plan of risk adjusting that you know that is operating in the world today that accounts for better than 20 percent of the differences?

Mr. THORPE. My point was that it is impossible to account for 20 percent because the remaining 80 percent is basically random, that what the issue here is that you are trying to—

Chairman STARK. You don't believe that, do you, random?

Mr. THORPE. Sure. If you look at anything, whether it is prior health use, or the most detailed medical history that you can get on any person, there is a very limited amount of an individual's year-to-year medical expenditures that are explainable. That is really the part that we are worried about: what is it about an individual that is observable, that is measurable, that we can tell in advance.

Chairman STARK. What if it turns out to be light fusion, just that—only accessible to the gods to know this. Where are we then if, in fact, it is random? Should we not then just assign risks randomly? I mean, isn't that the only really answer, if, in fact, we are stumped?

Mr. THORPE. No. Again, I wish I knew more about fusion, but I don't. That is not an area that I have a lot of credibility in. I think I was breaking this up into two areas.

The part that we can really—my concern here is that there is a very substantial part—I think maybe 20 percent, as I have talked about—of annual medical expenditures that is predictable, that a health plan and an individual can anticipate in advance. That is really the part that we are trying to come up with a way to make sure that as health plans enroll people, that they are adequately compensated for the risk of that person for that 20 percent.

The rest of the 80 percent by definition you are going to have to spread those across plans with respect to what their anticipated medical expenditures are.

Chairman STARK. Let's suppose they end up tremendously skewed in their population within the plans. What do we do?

Mr. THORPE. The probability of it happening is small. That is one of the reasons, going back to Mrs. Johnson's question about having larger pools: to the extent that you have larger pools, statistically the chance of that happening is quite remote.

Chairman STARK. Because you think that people will all jump into the pool and come out with a different fish than they went in with? In other words, you think that the instinct of the public will be like the Federal employee health benefit system where each year—we are about to go into it now. We just got our booklet this morning. Do you think there is going to be much change this year?

Mr. THORPE. In terms of people moving across plans? The amount of change each year is maybe 5 percent of people switch.

Chairman STARK. Infinitesimal. Do you know why people tend not to change?

Mr. THORPE. Well, let me say that in areas where there have been plans structured with defined contributions, such as Minnesota, for example, there was substantial change in the plans.

Chairman STARK. I mean Federal employees. In general, why do people not change?

Mr. THORPE. Pricing structure, how premiums are set up.

Chairman STARK. You think more than a relationship with a particular physician or plan or system?

Mr. THORPE. Essentially most people stay within a plan largely because they want to stay with a set of providers.

Chairman STARK. That is what I am getting at. Let's try the District of Columbia where a third of the people are in private plans and a third of the people are basically in the government plan and a third of the people are at risk. They are either in Medicaid or uninsured, mostly uninsured. And the plans have already testified that most of them don't have room to pick up 150,000 new.

How do you anticipate that we are going to take that population and have a community rate, take the 200,000 people that are at the highest risk and arguably at the highest cost, how are we going to spread that around and adjust the risk as between the Federal employee benefit system, the private insurance system that has got 200,000 people, and the new folks who come into the plan, how do you anticipate we will adjust that?

Mr. THORPE. I think it occurs again in two parts. First, is that the premium cap for the District, if that actually was an alliance, would be adjusted commensurate to the cost of providing care to people in the District.

Chairman STARK. But give me the scenario—where do you live in the District, what area?

Mr. THORPE. Right up on Capitol Hill.

Chairman STARK. Give me the scenario that suggests that you are going to join a plan that is out in Anacostia. You are going to stay with the plan you have got, aren't you?

Mr. THORPE. The idea is I would join a plan, not where the plan is located. I am joining largely based in part on the providers and plan, the price of the plan, the quality of the providers in the plan and so on. So the plan's location is less—

Chairman STARK. Let's take your boss who lives up in—or some of the White House team who live up in Northwest, way up in Northwest. Give me a scenario of where they are going to join a plan that has to go to D.C. General or to, again—finds its providers in Ward 7 and 8 under—and name the amount of money that they would be unwilling to pay per month to avoid doing that.

Mr. THORPE. Well, I don't know that I can speak to the latter.

Chairman STARK. Well, let's take 50 bucks, 100 bucks a month.

Mr. THORPE. I really don't have a way of answering that.

Chairman STARK. Guess.

Mr. THORPE. I don't like to guess, Mr. Stark.

Chairman STARK. Have you ever been—have you ever driven through Ward 7 and 8 in the evening? It is out Pennsylvania Avenue.

Mr. THORPE. I believe that I have, yes.

Chairman STARK. I am just suggesting to you that it is a long way from Chain Bridge Road and that it is not likely that people are going to do that, and what I am suggesting to you is that people who are in their plans where they are not apt to change regardless of what we do, and by the way, the District will be an alliance, at least as I read the bill, it can't be otherwise.

It isn't going to combine with Maryland under a Maryland group. Maryland would scream, so how do you envision, that is what I am getting at, anything but 200,000 people in Ward 7 and 8 and parts of Ward 2 all in the new plans, which we will have to supplement because no plans want to come in and bid on that group of people? How are we going to adjust that?

Say there are 10 providers around in town now. How are we going to collect from them? What are we going to pay to the new person to come in and take over that population? How do we do that?

Mr. THORPE. The important point to remember is that the risk adjuster is not at the alliance level, so the moneys that flow into the alliance would be redistributed from different parts of the city based on the risk of people that actually enroll in each health plan, even if health plans are geographically—

Chairman STARK. But follow me through. Let's assume that we are going to have two or three new health plans. The present health plans have testified they don't have room. You can understand the health plans have a critical mass.

If they are too far under it, they lose revenues, if they are too far over it, their capital facilities are strained. What they are all saying is they could take a couple thousand, Georgetown could maybe take a few thousand, but we are talking 150,000 to 200,000 people with either random access to a plan or no access to a plan and certainly no coverage.

Arguably you are going to need new plans for them, all right? The people who are currently being served are going to stay with their providers. History tells us this. They tend to. They like George Washington, they like Georgetown, they like their doctor, they like Sibley, they like where they are.

You would have to paint a new world for me to suggest that you will have anything other than some new plans concentrated geographically within what will be one alliance, the District of Columbia.

Now, how are you going to adjust for those new plans and—are you going to pay them, whatever it costs?

Mr. THORPE. No. Again, the plans as they come into different areas—let's say with the District example, that everybody in the District would have basically the opportunity to purchase private health insurance. They all come to the table——

Chairman STARK. Except that you have allowed the plans to not bid where they are up to capacity, right? You have said if you don't have the capacity, you don't have to bid for new beneficiaries.

Mr. THORPE. Right. But the notion is that in areas where there is under service, especially where there is a huge new market of people with health insurance cards, the opportunity for entry from other markets is very high.

Chairman STARK. Our testimony shows that is not the case. There are not a lot of people jumping up and down to serve this community. Let's just suppose that the testimony we had in this very room, Prudential said they won't. They will go out of the District of Columbia entirely before they will agree to open their plan to Medicare beneficiaries.

Mr. THORPE. I am sure that there are three or more, five or six that are willing to take their place, if that is indeed true because there is a substantial market.

Chairman STARK. At a limited cost.

Mr. THORPE. Based on their bid, and remember, Mr. Stark, that the money they actually receive based on who enrolls is adjusted demographically, it is adjusted on the reinsurance side and so on.

Chairman STARK. Let's get to that.

Mr. THOMAS. Mr. Chairman, before we get to that, I had one followup to my 5 minutes, which was an-hour-and-a-half ago.

I am just wondering when I might be able to get to my followup question from my 5 minutes of an-hour-and-a-half ago. Do you mind?

Chairman STARK. I am sorry. You want to do it right now? The gentleman——

Mr. THOMAS. I don't want to wreck your train of thought.

Chairman STARK. I apologize. The Chair felt that in waiting for the entire panel on the minority to have their questioning first, that by waiting until the end, I was accommodating the Members, but I apologize.



Mr. THOMAS. Mr. Chairman, I appreciate that and each of us took our 5 minutes, and each of us indicated that we had followup questions, but the 5 minutes had expired.

Chairman STARK. The gentleman's admonishment is well taken and the Chair is just so enthralled with the learning about risk adjustment that he completely apologizes to the Ranking Member, and I would recognize the gentleman from California.

Mr. THOMAS. This side of the aisle is just as interested in risk adjustment, and I think it is evidenced by the fact that every Member on the Republican side had questions which took up the entire 5 minutes and wanted to continue questioning, so I think there is a lot of concern about risk adjustment.

The statements that you have been making—there are just a lot incredible things you have said that from my understanding of what is occurring doesn't make either a lot of sense or even is factual.

You have indicated now that the President's plan in legislation is requiring every plan to offer, if not a fee-for-service, at least something that is different than what they are good at and have voluntarily moved away from. The example from Mr. McCrery in terms of the Kaiser plan being required to offer a point of service structure is different than what they are doing.

Don't you anticipate that some people are not going to be very good at estimating the costs in that area because they are now being forced under the legislation to do something that they are choosing not to do voluntarily? I mean, just a yes or a no because we have no time.

Mr. THORPE. No, I don't believe so because there is a very substantial market out there for point-of-service plans. We have a lot of experience based on—

Mr. THOMAS. I understand that, but Kaiser hasn't been doing it. And you are going to require Kaiser, if they offer something, to have to do it.

Mr. THORPE. I believe in some areas they are doing it, but I would be happy to check Kaiser specifically for you.

Mr. THOMAS. Mr. Claxton, you indicated that the uninsured and the nonworker's problem, which is a problem in urban areas, is going to be significantly modified by moving it to a national structure. My concern is that when Dr. Tyson was before the subcommittee last week and talked about the caps for lower incomes, she pretty much agreed that there was some institutionalized, and substantial, cross subsidies that would occur within an alliance, and that they would not be shifted to the national level, via uncollected debt, either by individuals or companies, I'm also referring to the cap in terms of families below 150 percent of the poverty level, the 40,000 capped at 3.9 percent.

Now, all of these are cross subsidies within an alliance that aren't federally funded and are built into the base of the alliance premium. They are going to have to be covered by increases within the alliance. Doesn't this make it more difficult in terms of a risk adjustment, given the cross subsidies that are going to occur more or less in different areas, depending upon how the alliance is structured? Yes or no.

Mr. CLAXTON. Yes, as I understand your question—I would answer yes or no, if I really understood your question. I am sorry. I don't.

Mr. THOMAS. My problem is this: You have indicated that you have got uninsured and nonworkers, who have been a problem, and we are going to shift that principally to a national level.

Our concern is as we have had testimony, and Dr. Tyson substantiated it, given the caps that you have on the premium amount paid by lower income folk or nonincome folk, and the fact that the alliance has to swallow nonpayment, either from individuals or from companies, that there is going to be more or less significant cross subsidization within an alliance.

For example, a consolidated metropolitan statistical area is a guaranteed alliance structure. You are going to have a lot of the uninsured, a lot of the nonworkers, and a lot of poor people in that structure. The cross subsidization in that structure will be probably higher than in other areas based upon failure to pay debt and the cap on subsidies under the President's plan.

Mr. CLAXTON. I understand that there is some cross subsidization that occurs because of the way bad debt is addressed, and I agree with that, that is true. It is not clear to me it affects risk adjustment.

Mr. THOMAS. You are not clear that it affects the cost of a plan?

Mr. CLAXTON. It is a per capita amount on everybody so—

Mr. THOMAS. And between alliances?

Mr. CLAXTON. Between alliances it certainly puts more of a burden on an alliance with high bad debt than on an alliance with low bad debt. That is certainly true.

Mr. THOMAS. OK, you have a map in front of you which shows that the so-called "HIPC" plan of California, in fact has noncontiguous areas in which it is serving, and you are able to criticize fairly precisely the California plan in a question that Mrs. Johnson had about some of the evidence that we are getting running counter to what we thought was gospel in terms of who signs up and the rest.

Is that going to be helpful to you now in anticipating the possibility that the legislation does not prohibit noncontiguous alliances, and that some States are in fact actively structuring themselves along lines that could easily become alliances that are noncontiguous, and does that concern you?

Mr. CLAXTON. It does help my understanding in the sense that I did not know this was the case. The notion of noncontiguous alliances does have problems from the point of view of red lining and other issues, and it is not as big a problem in the voluntary market here because this is not the only market for—

Mr. THOMAS. How about risk adjustment?

Mr. CLAXTON. Yes, it would be a problem.

Mr. THOMAS. Last question. California is moving in this direction. We ought to anticipate what is occurring in California. New York has recently moved toward community rating.

What do we know about the New York experience as brief as it is in terms of assessments to some plans and the anticipated proper assessment, fluctuations over a short period of time? Are our experiences with the community rating structure in New York rein-

forcing our theoretical beliefs about what was going to occur, or are they requiring us to rethink? Do we know?

Mr. CLAXTON. I don't believe that community rating in the context of a voluntary market—and given the other parts of the New York structure and the dominance of one carrier, its financial trouble and all the other things that occurred there—teach us very much about what would happen with community rating with mandatory insurance and the other market safeguards that are in the President's plan.

Mr. THOMAS. So what you are really saying is that recent real world experience, both in California and New York, really isn't worth very much because you have got to believe, and if you believe in what the President's plan is, you will then get a risk adjustment mechanism.

The problem is there just isn't enough faith among us to make sure that the system works, and to the degree we believe it will work. It seems to me we better start paying attention to the real world evidence we are collecting voluntary or not, which involves almost universal and—you know, you take a look at the Hawaiian experience on employer mandate that is up to 88 percent and the voluntary structure which is up to 85.

At some point, we are going to have to take the President's plan and begin to bump it up into the only reality that we have, because I don't know that there is enough faith among Members on both sides of the aisle to bring together a majority to pass the plan as it is written.

That is my only concern, and obviously we are getting more and more specifics as we move through 1993 and into 1994 because there are a lot more States doing a lot more things that are going to be helpful to give us a real world feeling.

Thank you, Mr. Chairman.

Chairman STARK. Dr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman. I am sorry I was not here for all of your testimony, but I would like to ask you a question about alliances.

Alliances in the bill seem to have borrowing authority, which raises a whole series of questions in my mind. If alliances bear the responsibility for risk adjustment and distribution of subsidies, don't they, in fact, bear risk, even if it is not direct underwriting risk. Borrowing authority sounds like if the alliances get in trouble, they can borrow money, and I am trying to make sense out of those provisions, where they are going to be at risk.

I would like to hear you talk about that.

Mr. THORPE. On general alliances are not risk bearing entities. In general they don't bear risk. What we have been talking about here today is simply how they distribute dollars within the alliance to adjust for the risk that health plans take.

The health plans in essence are the major risk-bearing entities and the alliances, in addition to being purchasing groups, would distribute moneys across health plans to recognize the risks that the health plans have accepted. So they in and of themselves don't bear risk.

Mr. McDERMOTT. But if they make a misjudgment in the assigning of their risk adjustment, they are held harmless somewhere?

Mr. THORPE. Yes. I mean, the risk adjustment methodology is to assist the health plans based on the enrollment, so the alliance in and of itself doesn't bear any residual risk.

Mr. McDERMOTT. So they can make adjustment, give money to a particular health plan, but they have no responsibility for that.

Mr. THORPE. Well, the methodology is determined nationally of how the risk adjusters are done, and the alliances would implement the nationally determined risk adjustment mechanism.

Mr. McDERMOTT. And then the health plan would obviously have the ability to come back and say, "well, you didn't do the risk adjustment right, we want to have you adjust it again, you have made a mistake here." Is there a mechanism in there by which they can appeal the risk adjustment?

Mr. THORPE. Well, again, the idea is that while we think right now it would be completely adequate with the several steps that I just talked about in the first part of my testimony, that there will be structural changes, that in addition to that, there will be the demographic adjusters, the reinsurance pool, and potentially the use of self-assessed health status. The National Board is in charge of coming up with a methodology. We would hope that during 1 to 1½ years we can get some of the best thinking available, which we already have. You will hear more testimony today about what other additional factors that we should use that can predict observable factors of individuals to include in the methodology. The National Health Board, I am sure, would incorporate that in developing a final approach to this.

But in terms of appeals, there is a national approach that the Board would determine and it would be based on, again, the best available technology that we have that can detect observable reasons why individuals come into plans and why health plans may try to attract certain types of individuals.

Mr. McDERMOTT. Is it then, from your standpoint, that the alliance can never go broke, they can never be bankrupted?

Mr. THORPE. That is correct.

Mr. McDERMOTT. And what happens to the population? Let's suppose that suddenly, in California there are many more people who are unable to pay their own premiums who have to be subsidized. There is an unlimited pot at the Federal level that the alliance can get money from and take care of that; is that it?

Mr. THORPE. There is borrowing authority that the alliance has.

Mr. McDERMOTT. Borrowing from the Federal Government? Is that borrowing from the Federal Government, the alliance would say—

Mr. THORPE. I am sorry. Just for clarification, are you talking about if there is bad debt in the area?

Mr. McDERMOTT. No. I was talking about—well, I don't know what you would describe as bad debt. I am thinking of bad debt in the present sense.

Mr. THORPE. Under collection of premiums.

Mr. McDERMOTT. Yes, OK, there is bad debt in the area. In other words, suddenly, because of some event, there is 10,000 people laid off and no one can pay their premium, so you can't collect their premium.

Now, the alliance has got to pay the money to the health plan, but they don't have any money. Where do they get the money from?

Mr. THORPE. Actually, as part of the calculations that we have made in developing the cap entitlement, which is laid out in the legislation, we have included, and we have talked about this I think in several different areas, a 15 percent calculation in that calculation.

Let me give you a quick example of one of the calculations that we made. We did a calculation that said suppose that the unemployment rate increased 2 percentage points, which I think is getting exactly to your question, what would happen then to the amount of discounts required from the Federal Government? And we made that calculation and found that about yearly that it would increase the discount pool by about \$4 billion.

What we did in our calculation of the discount pool that is laid out in the legislation then is we took our best estimate of what they would be, which I already think is—at some other point, I would be happy to come back and talk to you about the methodology that we used to derive that—conservative in and of itself, then on top of that, we built in a 15 percent cushion.

This example, the \$4 billion increase in discounts required from a downturn in the economy, is well within that 15 percent cushion. In fact, it adds maybe 5 or 6 percent over and above our best estimate. So we think that the discounts that we have laid out in the statute are much more than adequate to take into account even something as substantial as a 2 percentage point increase in the unemployment rate.

The money is there. It is laid out as part of the cap entitlement.

Mr. McDERMOTT. So you are really saying in your testimony that the full faith and credit of the United States Government stands behind the health care system no matter what happens? You believe you have built in contingencies, but you are saying that the Federal Government will provide the money to the alliance to pay the local health plan, the accredited health plan if there is some problem?

Mr. THORPE. There is authority each year to disburse moneys up to that cap, and then if there are moneys left over, then they can roll over.

Mr. McDERMOTT. And if the National Board has made a mistake in its target premium, the local alliance is not responsible for it. They are simply going to be handed this number from on high, from the Federal level.

Mr. THORPE. Right. The premium caps would be determined by the National Board, but they would take into account the cost of providing that comprehensive benefit package in that alliance area.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

To followup on that specific point, the unemployment compensation system is run in a similar fashion, but after there has been borrowing, unemployment comp premiums go up to repay the borrowing. Under your system, how do—how does the borrowing get repaid?

When the health alliance has to borrow, do premiums then go up to repay?

Mr. CLAXTON. If I can address that. There are several different reasons for borrowing. One is for premium misestimations, which have to do with estimating the per worker premium.

Mrs. JOHNSON. I understand that.

Mr. CLAXTON. That is repaid through increases in premiums in later years. There is another set of ability to borrow that is based on what we call administrative errors, and that is where an alliance has not properly administered the discount program, and therefore has given discounts in excess of its error rate. That is a responsibility of the State to make up that money, and the third—

Mrs. JOHNSON. Is there any prohibition for them making it up through premium increases?

Mr. CLAXTON. Yes.

Mrs. JOHNSON. So the State legislature sets that out?

Mr. CLAXTON. Not a prohibition on them making it up through premiums.

Mrs. JOHNSON. In the one instance, they are explicitly allowed to make up it up.

Mr. CLAXTON. In the second instance, the State's maintenance of efforts has to make it up.

The State has to make it up through general revenue, and the third area, where there is borrowing authority, is if, under the way the bill is structured, people are unemployed, they don't owe their employer's share of the premium at all until the end of the year, and so there might be some period of time where the alliance's obligations do not meet its current cash, and in that case, the borrowing would be repaid when the new money comes in.

Mrs. JOHNSON. Thank you. So basically the State is liable for health alliances' administrative failures, and for health care cost miscalculations. Premiums can go up. Just to get back specifically to risk adjuster. Clearly, size matters from all you have been saying. Size matters.

By making each accountable health plan provide not only a managed care format, but also a fee-for-service program, you are assuring that only very large providers will be in the market. Given only large companies offer accountable health plans, why isn't the traditional mechanism of reinsurance then an adequate one? Because you only have large companies with large pools and traditionally reinsurance has managed risk adjustment adequately in that market, and even in your proposal you rely on reinsurance for the first year or two?

Mr. THORPE. With respect to the first point, Mrs. Johnson, the opportunity for a plan to offer a point-of-service option really only affects the group model HMOs because by definition, the point-of-service plan and fee-for-service plans, and community-based centers, which would largely be fee-for-service derivatory, are offering something that falls within that requirement, so this really is just something that perhaps is specific to a staff group model HMO.

Mrs. JOHNSON. Many companies don't offer all three possibilities.

Mr. THORPE. No, you don't have to. I could be a fee-for-service plan and just offer fee-for-service. I could be a point-of-service op-

tion plan and have a point-of-service option, and just offer the point-of-service plan.

The issue here is for a—if I am today just solely a staff model HMO, that is a separate plan and a separate premium.

Mrs. JOHNSON. If you are an HMO, you must offer a fee-for-service plan. If you are a fee-for-service plan, you don't have to offer an HMO.

Mr. THORPE. That is correct.

Mrs. JOHNSON. OK. OK. That is an inequity and an inconsistency I didn't pick up through your first explanation. Let me then ask my final question and that is, you say that alliances can adjust premiums to make up for risk problems, and yet you said early in your testimony that the National Board will determine premium targets.

Now, in the legislation, those premium targets are determined as a consequence of the amount of health care cost increase that is to be allowed that year so that when health care cost increases allowable fall to inflation plus 1.5 percent and then inflation plus 1 percent, inflation plus 5 percent.

In other words, those premium targets are going to decline as a matter of Federal law. Now, as those premium targets decline and therefore as the premiums decline, what happens when the premium that the National Board sets and the health alliance sets falls below the premium that the health alliance needs to allow to be charged to offset legitimate underestimation of risk that they think should be passed on to the accountable health plans?

There are going to be two sets of allowable premiums and there is going to be increasing disparity between those as the formula in the legislation drives premiums down and experience doesn't.

Now, how do you anticipate reconciling those differential premiums? And who will win? Who has the final say? Does the targeted premium driven simply hold and any adjustment is foregone as is currently the way government manages reimbursements?

Mr. CLAXTON. As I understand your question, it is how do the premium targets work and what happens if the health plan increases in costs are more than what is allowed by the targets? There is a two-step process.

The first is that the alliance goes back and tries to negotiate with plans. If the weighted average premium in the alliance on an anticipated basis is going to be higher than the premium target, the alliance goes back and tries to negotiate with the health plans to try to bring their costs down.

If they cannot, those plans that have higher than allowed rates of growth have a reduction in the amount that is paid to them and at the same time, there is a reduction in the amount that they pay their providers.

Mrs. JOHNSON. So what you are saying is that the winner in all of this is the National Health Board and the premium targets they set, and if the weighted average premium is higher than the targeted premium, then the weighted average premium goes out the window.

Now, the weighted average premium can be higher, particularly if you have to pay back some underestimation of the preceding year, but if that is higher, then in fact the premium dictated by the

Board through the targets is the one that holds sway and prices are simply reduced accordingly.

I would remind you that this is exactly how the global budget in Medicare works. It is precisely what is reducing access to internal medicine—to internists in my State of Connecticut, because it is the global budget that holds sway, and if volume times price doesn't work, price is reduced and that is the system that you are offering us, and when I look at the history of Medicare and the VA system where this approach is more advanced, I find it concerning.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Claxton, what you just said is what we were worrying about a minute or two ago about the southeast District of Columbia which really says if the cost in the area is up, they go up. Then they have to squeeze the providers. It is going to be tough enough to get providers there in the first place.

Mr. CLAXTON. It is the alliance-wide weighted average premium.

Chairman STARK. I understand that. But the new people who come in to help us take care of this 150,000 or 200,000 population, if their costs are high and consequently their premiums have to be high to keep from going broke, then you ratchet down and then you ratchet down on the providers.

What is going to happen is the providers are just not going to offer it. That is the part of the system that troubles me.

One more time, Dr. Thorpe, can you tell me any place in the country where a risk adjustment system is operating that we could observe or begin to think it even closely resembles the risk adjustment system you envision for this operation? Is there a plan anywhere that is currently in use?

Mr. THORPE. To my knowledge, the only place I have seen it operating is in Medicare. It is a completely different system because Medicare doesn't have the structural requirements preceding the demographic adjustments.

Chairman STARK. I am going to ask you about some data. The First Lady suggested to us some time ago that we and our staff could have access to data. I think you have been referred to as the chief number cruncher in this operation.

Do you have data on the amounts that Medicare beneficiaries would pay if they were enrolled in the alliance plans and the amounts you anticipate will be paid in the aggregate by Medicare to the plans?

Mr. THORPE. We can provide that.

Chairman STARK. Do you have similar data—you may not because this was just changed by the distinguished Senator from West Virginia on what the VA beneficiaries would pay and what you anticipate would be paid to take care of that decrepit system. Could we have that?

Do you have information on the value of the minimum benefit package as compared to Medicare benefits as modified? Could we have that?

Mr. THORPE. Yes.

Mr. STARK. Thank you.

Do you have an estimate of the number of Medicare beneficiaries that you anticipate will enroll in the alliance plans and the aggregate dollars that would be paid from the trust fund to those plans?



Mr. THORPE. Yes, we could provide you that as well.

Chairman STARK. On the distributional question, may we have the number of employers effected by the 7.9 percent cap in whatever distributional industry type breakdowns that you have.

Mr. THORPE. Sure. We can provide it by the specific caps.

Chairman STARK. The subsidies to low-wage small firms, the distribution of average wage by firm size and the current provision of health care in that population?

Mr. THORPE. We can provide you the baseline data.

Chairman STARK. On premiums, regional and State variations in current health spending.

Mr. THORPE. We can provide that, sir.

Chairman STARK. Back to the question that I so ineloquently asked Mr. Claxton earlier, my staff writes this better than I can say, the analysis of interactions between the impact of low-income subsidies and regional variations in premiums. That is what we were kind of referring to in the district.

Do you have information on that?

Mr. THORPE. We have looked at it in our modeling certainly because the discounts are related to average wage of firms. So to the extent there is a relationship that we know exists between payroll and—

Chairman STARK. You are not going to suggest you give us a copy of your model.

Mr. THORPE. No, I would not make such a suggestion. It would be too painful.

Chairman STARK. Can we play games with it? You are not sure you have that data is what you are saying?

Mr. THORPE. We will be happy to give you as much data along those lines as we do have.

Chairman STARK. Do you have data on the assumptions and analysis supporting the initial premium level estimates and the assumptions regarding utilization increases in that because of the previously uninsured?

Mr. THORPE. We will have that for the uninsured as well as the long-term.

Chairman STARK. What impact do you see on the VA, which is kind of a strange—I don't know if you have the data. There are a lot of Medicare or CHAMPUS people suddenly going to VA hospitals. I don't know how much data you have on that, but that would be very interesting to us for an entirely different reason. I appreciate it.

[The following was subsequently received:]



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of the Assistant Secretary  
for Legislation

Washington, D. C. 20201

MAY 12 1994

Ms. Diane Kirkland  
Subcommittee on Health  
House Committee on Ways and Means  
1102 Longworth House Office Building  
Washington, D. C. 20515

Dear Ms. Kirkland:

Listed below is the information requested for the record of the hearing on risk adjustment under the Health Security Act, held before the Subcommittee on Health on November 9, 1993.

What are the amounts that Medicare beneficiaries would pay if they were enrolled in the alliance plans and the amounts you anticipate will be paid in the aggregate by Medicare to the plans?

Medicare eligibles who are enrolled in alliance health plans because they or their spouses are workers will pay their family share (20 percent) of the community rated premium, minus any low-income discounts applicable to them. Because these Medicare eligibles will be part of a broad-based, community-rated risk pool, their share of the premium will, on average, be lower than the Part B premium they would pay under Medicare. Those who are covered under an alliance will have the option to buy Part B coverage (projected to cost approximately \$51 per month in 1996), which will cover cost sharing for Part B services in the alliance. Actual alliance premiums will vary by region, depending on how states draw alliance boundaries.

For those Medicare beneficiaries who are not covered through an employer and who choose to remain in an alliance, Medicare will contribute to the alliance an amount equal to the average cost per Medicare beneficiary. The beneficiary's family contribution will be set based upon the difference between the health plan's premium for Medicare enrollees and the Medicare program contribution. These exact amounts have not been estimated in advance.

What would the VA beneficiaries pay, and what would you anticipate would be paid to take care of that decrepit system?

Veterans and their dependents will be eligible to join the VA health plan through their regional alliance. If a veteran chooses to join the VA plan, and is "mandatory eligible" (service connected veterans and low income veterans), then all premiums and cost sharing will be covered by appropriations from existing legislative authority. Other veterans and their dependents will be responsible for a twenty percent premium payment like other members of the alliance. If a veteran with discretionary eligibility chooses not to join the VA plan, he or she will continue to be eligible for all VA benefits which exceed the comprehensive standard benefits package.

What is the value of the minimum benefits package as compared to Medicare benefits as modified?

Once drug benefits are added to Medicare, the basic difference in the two benefit packages is that the HSA benefit package will have an out-of-pocket catastrophic stop loss limit and the Medicare benefit package will not. The estimated premium difference associated with stop loss protection and other benefit provisions (e.g. prevention) in the guaranteed benefits package would be approximately 10 percent.

What is the number of Medicare beneficiaries that you anticipate will enroll in the alliance plans and the aggregate dollars that would be paid from the trust fund to those plans?

Under the Health Security Act, 5.4 million Medicare beneficiaries will receive employer-based coverage through an alliance. In addition to the Medicare beneficiaries currently receiving coverage through their employers, another 3.2 million beneficiaries who work, or whose spouses work, will receive coverage through an alliance by the year 2000.

Employers, rather than Medicare, will be primarily responsible for covering the health care and premium costs of full-time, Medicare-eligible workers and their spouses, saving Medicare an estimated \$25 billion over five years. For part-time or part-year workers, Medicare will fill in the gaps on premium amounts beyond the employer and beneficiary share. Medicare will also cover cost-sharing for Part A services. The \$25 billion savings estimate includes these trust fund costs. For Medicare eligibles who do not work and choose to remain in an alliance, Medicare would reimburse the alliance based on an average Medicare per capita cost. We do not have estimates of these amounts.

What is the number of employers affected by the 7.9 percent cap in whatever distributional industry type breakdowns that you have.

The Administration has not conducted an analysis of employers affected by the 7.9 percent cap by industry. However, the attached chart illustrates employer's premium payments by percent of payroll and firm size.

What are the subsidies to low-wage small firms, the distribution of average wage by firm size and the current provision of health care in that population?

1. See "Effect of a "Dual Cap" Approach to Employers Subsidization."
2. Please see attached table, "Table of ESize by Insstat," where ESize is number of employees in an organization, and Insstat is the persons insurance status.

What are regional and State variations in current health spending?

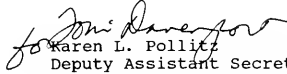
The best source for data on current regional and state variation in health spending is the Fall 1993 article in Health Affairs by Levit, et. al. They estimate based on HCFA national health account data, regional spending as a percent of U. S. per capita spending ranges from 113% in New England in 1991 to 83 percent in the Rocky Mountain region, a swing of 30%. State average annual growth rates between 1980 and 1991 ranged from a high of 13.4% in New Hampshire to a low of 8.2% in Illinois.

What impact do you see on the VA?

The VA will establish health plans within alliances, and will provide comprehensive standard benefits to its enrollees. The act would authorize Medicare reimbursement for those with discretionary eligibility, and will compete for enrollees in alliances.

You may contact Carl Taylor at (202) 690-7450 if you have any questions regarding these responses.

Sincerely yours,

  
Karen L. Pollitz  
Deputy Assistant Secretary  
for Legislation (Health)

Enclosures

AVERAGE WAGE AND SALARY INCOME OF WORKERS BY FIRM SIZE  
MAY 11, 1994

NOTE: THE AVERAGE IS COMPUTED FOR WORKERS WITH WAGES.

SOURCE: MARCH 1993 CURRENT POPULATION SURVEY

FIRM SIZE (NUMBER OF EMPLOYEES)	AVERAGE WAGE
1-9	\$15,414
10-24	\$17,781
25-99	\$20,383
100-499	\$22,196
500-999	\$23,871
1000+	\$25,880
ALL WORKERS	\$22,019

NUMBER OF WORKERS IN SMALL FIRMS BY KIND OF HEALTH INSURANCE  
MAY 11, 1994

SOURCE: MARCH 1993 CURRENT POPULATION SURVEY

PERSON COUNTS ARE IN MILLIONS

INSURANCE TYPE	.....FIRM SIZE.....			UNDER	ALL
	1-9	10-24	25-99	100	WORKERS
EMPLOYER-GROUP					
EMPLOYEES OR RETIREE	4.4	4.3	9.0	17.7	66.8
DEPENDENTS	4.8	2.6	3.0	10.4	20.8
MEDICARE	0.7	0.3	0.4	1.3	2.2
MEDICAID	0.7	0.4	0.5	1.7	3.3
VA OR MILITARY	0.3	0.2	0.2	0.8	2.5
OTHER PRIVATE	2.9	1.2	1.3	5.4	9.0
NOT INSURED	5.4	3.0	3.5	11.9	20.1
TOTAL	19.3	11.9	18.0	49.2	124.9

NOTE: SOME PERSONS HAVE MORE THAN ONE KIND OF INSURANCE.  
IN THIS TABLE, PERSONS WITH MORE THAN ONE KIND OF INSURANCE  
ARE COUNTED IN THE FIRST INSURANCE CLASS IN WHICH THEY APPEAR.

Chairman STARK. I want to thank the panel very much.

Mr. Lubitz, we do career counseling here in our spare time. I think executive level one is what you ought to shoot for.

I thank the panel very much. We will look forward to grinding through some of the more detailed information.

Mr. THORPE. Thank you, Mr. Chairman.

Chairman STARK. Our next panel is witnesses with expertise in the area of risk selection and risk adjustment. It will consist of Alice Rosenblatt, who is testifying on behalf of the American Academy of Actuaries. She is chair of the academy's Risk Adjustment Work Group and is senior vice president and chief actuary of Blue Cross and Blue Shield of Massachusetts.

Dr. Gerard Anderson is director of the Johns Hopkins Center of Hospital Finance and Management.

And Dr. Harold Luft is professor of health economics and acting director of the Institute of Health Policy Studies for the University of California in San Francisco.

The Chair is going to recess for about 2 minutes. At that point, we will proceed with Ms. Rosenblatt's testimony.

[Recess.]

Chairman STARK. Let me ask just a generic question of the panel. Would you excuse me if I eat?

Mr. ANDERSON. Fine.

Chairman STARK. I want to welcome the panel here. It is a complex issue that we are going to deal with.

Ms. Rosenblatt, why don't you lead off?

**STATEMENT OF ALICE ROSENBLATT, CHAIR, RISK ADJUSTMENT WORK GROUP, AND SENIOR VICE PRESIDENT AND CHIEF ACTUARY, BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS**

Ms. ROSENBLATT. Thank you for giving me the opportunity to speak today, Mr. Chairman.

First I would like to make a correction. Thank you very much for calling me a doctor, but I am not. I have a master's, but not my doctorate.

I am speaking for the American Academy of Actuaries' Risk Adjustment Work Group. I will be addressing: why it is necessary, the methods and current status of those methods.

There are two aspects of the Health Security Act that create the need for risk adjustments. Without risk adjustment, these would create several problems, including the fact that some health plans currently have better services for certain illnesses. I think that was mentioned in some of the questions before.

There might be special clinics for treatment of diabetes, AIDS or cancer within the health plan's network. These will attract high-risk individuals. Without a risk adjustment mechanism, the plans providing the special services would be penalized.

In spite of guaranteed issue and renewal requirements, health plans will attempt to avoid high risks. This will have an impact on community rates. Studies have shown that approximately 4 percent of those currently insured within a plan generate about 50 percent of the cost of that plan. If we eliminate that 4 percent, we can reduce the community rate by up to 50 percent.



Chairman STARK. Say that again.

Ms. ROSENBLATT. If we can find a way as a health plan to eliminate the 4 percent that will generate those costs, since they generate 50 percent of the costs, we could lower the community rate by up to 50 percent.

This is a very high incentive for avoiding the high risks. The plans that are able to do that and that do that sometimes in the current environment will not only increase their market share but also increase their profits.

In today's marketplace, there are many different practices that exist. If we don't have a risk adjustment mechanism in a new environment that requires community rating, then those plans that were using medical underwriting and that were using aggressive rating practices will be rewarded. And it penalizes the carriers that were using guaranteed issue and renewal and community rating and rewards those carriers that were using the aggressive rating practices and medical underwriting. These differences can be as much as 35 to 80 percent of premium, particularly in the individual market.

Ideally, one wants to provide the consumer with a choice of plans that is based on the plans' ability to manage the medical and administrative costs. We should not be giving the consumer a choice that reflects the plan's ability to select good risks.

The first step in doing risk adjustment is to do something we have called risk assessment. This quantifies the expected health care costs of one population compared to another. In the context of the Health Security Act, we would compare the risk profile of the various health plans in the regional alliance with the risk profile of the total alliance.

Step 2 is risk adjustment. In the context of the Health Security Act, there would be transfer payments made between the health plans. Health plans with higher-than-average risk populations would receive monetary payments and health plans with lower-than-average risk populations would make the monetary payment.

With community rating, these transfer payments would be translated into premium differentials and would allow the consumer to compare prices that reflect medical management and administrative efficiency.

Chairman STARK. Would this all be done prospectively or would a lot of this be retrospective?

Ms. ROSENBLATT. There would be a possibility for prospective, retrospective or a combination of both. What is done today is what we call an up-front risk adjustment, which is pricing that reflects age, sex and health status. We could do some methods prospectively and attempt to estimate what the extent of the risk adjustment will be, and then have a retrospective settlement at the end of the period.

Chairman STARK. Retrospective settlement in a sense tends toward cost reimbursement, doesn't it?

Ms. ROSENBLATT. Some forms do. One method of doing a combination prospective and retrospective adjustment be similar to what is done in New York today. At the start of the system each carrier had to estimate the demographics of the population they were insuring for the quarter. Due to adds and deletes during the

quarter, the actual numeric value of the age, sex factors would be different and there would be a retrospective adjustment for that.

Chairman STARK. Thank you.

Ms. ROSENBLATT. There are many risk assessment models that exist today. A simple model would do what we have been talking about using age and sex adjustments. More complex models would use prior history. In our written testimony we have included examples of some of the existing models.

The best approach would probably be a prospective method because it would limit the uncertainty involved in premium development.

There are certain concerns that we have about risk adjustment. These concerns are being offered in terms of thinking about what type of risk adjustment would work. These are some of the things we want to think about.

We don't want to introduce more bias than exists today due to the risk adjustment mechanism. We want to prevent providers from influencing the measurement used by the risk assessment by changing the course of treatment that they would normally offer.

For example, if providers are rewarded for providing more treatment, we certainly would not have a good system. We would like something that is simple to administer. We believe there will be trade-offs between accuracy and administrative costs. We don't want to have 1 percent monetary transfers, that is, 1 percent of premium transferring between health plans, but have it cost 3 percent of premium to determine the amount of those transfers.

The American Academy of Actuaries paper discusses our concerns about administrative complexity and bias of many existing models. We will be happy to provide a copy of this report for the record.

However, we believe risk adjustment is necessary and we believe that interim solutions are possible while research continues. We think an adjustment method that accounts for some of the risk differential is better than a method that accounts for none of the risk differential.

We recommended the system like the one currently used in New York State as a short-term solution. It uses prospective demographic adjustments as well as a mandatory high-cost medical condition reinsurance system.

In conclusion, we believe risk adjustment is necessary in a managed competition system with community rating. Methods exist that are suitable such as the method used in the State of New York.

The American Academy of Actuaries will do all we can to help in the development of both short and long-term solutions.

Since there were some questions before about self-insurance, I would like to add that today many self-insurance plans offer multiple choice to the consumer and that those plans that offer multiple choice including HMO as well as an indemnity plan option are introducing a selection bias through that choice. Some employers have attempted risk adjustment methods to avoid the adverse selection cost of that choice.

[The prepared statement follows:]

SUBCOMMITTEE ON HEALTH  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
HEARINGS ON  
RISK SELECTION & HEALTH PLAN ADJUSTMENT ISSUES  
IN HEALTH CARE REFORM

TESTIMONY  
BY THE  
RISK ADJUSTMENT WORK GROUP  
AMERICAN ACADEMY OF ACTUARIES

November 9, 1993

The American Academy of Actuaries is a national organization formed in 1965 to bring together into a single entity actuaries of all specialties within the United States. In addition to setting qualification standards and standards of actuarial practice, a major purpose of the Academy is to act as the public information organization for the profession. Academy committees regularly prepare testimony for Congress, provide information to congressional staff and senior federal policy makers, comment on proposed federal regulations, and work closely with state officials on issues related to insurance.

The Academy's 15-member Risk Adjustment Work Group prepared this testimony. The group is comprised of a diverse mix of health actuaries and health policy professionals. Members include actuaries who are employed by insurance companies, national health associations and government health programs, as well as actuaries who work as independent consultants. Two health care economists and a physician also serve on the work group. In addition, the expertise of other senior health actuaries and knowledgeable professionals was drawn upon to prepare this testimony. The work group produced a study paper in May 1993, Health Risk Assessment and Health Risk Adjustment--Crucial Elements in Effective Health Care Reform, which is available through the Academy.

## INTRODUCTION

This testimony addresses: (1) Why risk adjustment is needed when insurers in a private competitive market are required to community rate, (2) the importance of risk assessment in achieving meaningful risk adjustments, (3) the current status of risk assessment models, and (4) the Academy work group's suggestions for the most practical way to proceed with risk adjustment if the President's proposed Health Security Act of 1993 is enacted.

## THE NEED FOR RISK ADJUSTMENTS UNDER THE PRESIDENT'S PROPOSAL

In an unregulated competitive private health insurance system, each insurer assesses the potential risk of individuals and groups at the time the group is insured. The insurer then charges a premium that reflects the individual or group's expected cost to the insurer. Under this financing system, older individuals, or groups dominated by such individuals, will pay higher premiums than younger individuals and groups. Similarly, those who are already known to be in poor health will pay higher rates than individuals who are currently healthy. Under this system, there is no need to make transfers among insurers to reflect differences in the risks the insurers have undertaken. These differences have already been accounted for by differences in the premium rates the insurers have charged the higher and lower risk groups or individuals they have insured.

The President's proposed Health Security Act of 1993 retains private insurers and competition among them. However, the proposal departs in two fundamental ways from the classic approach to pricing private insurance. First, the proposal requires that each insurer accept everyone who applies for coverage and guarantee the renewal of that coverage as long as the applicant is willing to pay the premium. This practice is referred to as guaranteed issue.

Second, each insurer would have to charge the same premium to everyone insured within the same geographic area. The only differences permitted in an insurer's premiums would be those reflecting differences in costs for different family types. This does not mean that all insurers would charge the same premium. For example, more efficient insurers could be expected to charge lower premiums. The practice of charging the same rate for everyone within a geographic area is called community rating.

It is possible to imagine a competitive private health insurance system based on guaranteed issue and community rating without any type of risk adjustment mechanism. But, as different as the outward appearance of that system might be, it could produce many of the results that have led to criticism of the current system.

Without risk adjustment, insurers would continue to compete based on attempts to avoid high risk individuals and groups. Four percent of the claimants of an insurance plan generate as much as 50% of the claim dollars. In the absence of risk adjustment, carriers in the regional alliance would have strong incentives to avoid attracting high risk individuals. Other factors being equal, insurers with better risks could charge lower community rates than carriers insuring high morbidity individuals and would also have the opportunity to be more profitable.

It should be expected that there will be significant differences in risk characteristics among enrollees in the various health plans during the initial few years of a reformed health care system. One reason is that, to date, different types of insurers have been subject to different regulations. In states without small group insurance reform legislation, some carriers use medical underwriting to exclude high-risk individuals from their insurance plans. Other carriers in the same market, such as Blue Cross/Blue Shield plans, are often required by law to insure everyone who applies who can pay the premium.

In addition, current rating practices also differ among insurers. Some insurers in a given market may be using community rating, whereas other insurers charge different premiums based on a person's age, sex, location, industry, health status, health experience, and how long they have been insured.

Even in states that have enacted small group insurance reform legislation, these underwriting and rating practices may still be prevalent in the individual insurance market. Moreover, for group insurance there is often a phase-in period for newly legislated restrictions on rating practices, and, even after full implementation, demographic rating often is permitted, as well as limited use of such rating variables as health status and health experience.

Studies have shown that if the risk profile of a carrier that has been using medical underwriting and aggressive rating is compared to a carrier that has been using guaranteed issue and community rating, there can be differences in expected morbidity costs that translate into 35% to 80% differences in premium.

Thus, if the Clinton approach to pricing were adopted without a risk adjustment mechanism, a health plan might have the lowest rates in the regional alliance, but that could be due to the carrier's past practice of medical underwriting and aggressive rating based on risk characteristics, as opposed to more effective medical management and administrative efficiency.

Although all of the ramifications of moving from the current pricing system to the one proposed in the Health Security Act cannot be anticipated, it is clear that the transition is potentially very chaotic. There could be a good deal of price instability, and it will likely take some time for the benefits of managed competition to begin to work. For most insurers setting premiums in the short run will involve enormous uncertainty. In such an environment, there would be a tremendous incentive for insurers to take advantage of any gaps in the regulatory structure and

attempt to create new ways to avoid the worst health risks in order to assure survival, gain profitability, or simply minimize the risk of insolvency.

An appropriate risk adjustment mechanism would not solve all of the transitional problems. Insurers would still be faced with serious pricing problems, at least in the short run, and solvency concerns would remain. Other Academy work groups are studying these issues and will share their findings with the Subcommittee as they become available.

However, an appropriate risk adjustment mechanism would contribute to the successful operation of the new pricing system in two ways. First, risk adjustment would protect health plans that enroll a disproportionate number of high utilizers of health care. Second, and more important from the perspective of the designers of the President's proposal, risk adjustment would tend to eliminate those differences in premiums arising solely from differences in the health risks of those insured. The remaining premium differences among insurers would, then, reflect differences in the cost and effectiveness of care, rather than whether an insurer happens to end up with a group of insured that are, on average, higher or lower health risks.

The remainder of this testimony will discuss the general approach used to measure relative risk among insured groups, the state of the art of such measurement, the Academy work group's concerns about risk adjustment, and finally, suggestions for how, as a practical matter, risk adjustment could be dealt with most successfully under the President's proposed Health Security Act of 1993.

#### RISK ADJUSTMENT REQUIRES RISK ASSESSMENT

Adjusting for differences in risk among health insurers is a two-stage process. The first part of the process is assessing the health risk associated with individuals and groups, which means measuring on some objective basis the amount by which one group's expected health care costs will exceed the expected health care costs of another group. Under the Health Security Act, where health plans compete with each other within regional alliances using community rates, a risk assessment model would be used to compare the risk profile of each health plan's population with that of the total population of the regional alliance. For example, a given risk assessment model might predict that the expected health expenditures of one insurer is 20% higher than the average for the total population of the regional health alliance. Another insurer's expenditures might be predicted to be 20% below the average for the health alliance.

Once risk assessments are done, the next step is to use these assessments to perform risk adjustment. A risk adjustment methodology could be used to transfer payments among the various health plans in the regional alliance. A health plan with a higher-than-average risk population would receive a monetary payment, and a health plan with a lower-than-average risk population would make a monetary payment. With community rating required, these adjustments would allow premium rates to better reflect medical management and administrative differences, rather than risk profile differences.

#### CURRENT STATUS OF RISK ASSESSMENT MODELS

There are many different methods for assigning relative risk classifications; each is distinguished by the model used to determine the risk categories. For example, a risk assessment based on self-reported health status would assign a numerical score to people based on what items they included in a report on their own health. A demographic relative risk factor would segregate individuals into risk categories on the basis of demographic factors such as age/sex or family status. A diagnostic or prior-history risk assessment method might segregate individuals into risk categories based on illness or number of hospitalizations in the previous year.

Risk assessment models can range from the very simple to very complicated. The simplest type of model for doing risk assessment would use age and sex characteristics only, since many studies show that age and sex correlate well with health care cost differentials. Other models currently being discussed include questionnaires on health status and models that use prior medical history. The prior history models are generally more complicated because of the amount of data the measurements require and the more complex interactions of the data elements.

Examples of risk assessment methods generally referenced today include:

Ambulatory Care Groups (ACGs), a model that classifies risk using age/sex and ICD-9 diagnoses assigned during ambulatory care;

Diagnostic Cost Groups (DCGs), a prior-history risk classification system that uses inpatient hospitalization data;

Payment Amount for Capitated System (PACS), a model that classifies risks using age/sex, disability status, chronicity, major diagnostic category and level of ambulatory resource use;

RAND 36--Item Health Survey 1.0, a self-reported health status measure consisting of 36 questions; and

Robinson-Luft, a model that applies a series of conditional probability regression equations to assign relative risk factors based on data from an employer's database.

Many of these risk assessment models require vast amounts of historical data on the individuals to be insured. Such methods are not without fault. They are expected to be costly to implement, have timeliness problems, may reward inefficiency and inappropriate treatment of patients, and are not, for the most part, fully tested for accuracy and practicality for performing risk adjustment in a competitive environment.

The Academy work group reviewed existing risk assessment methodologies and was unable to recommend any one method. The work group strongly recommends that further research be done. The research needs to focus on the cost and administrative difficulties of using any of the methods that depend on prior history to perform risk assessment.

#### REQUIREMENTS OF THE PRESIDENT'S PROPOSAL

Health risk assessment and risk adjustment is relevant to three separate areas addressed by the Health Security Act. The first is the mechanism through which transfers are made among health plans within a health alliance to adjust for differences in expected health care costs due to differences in the populations insured. Here the Act states that the Federal Board will develop a risk adjustment and reinsurance methodology not later than April 1, 1995.

The Health Security Act contains a second form of risk adjustment in the computation of the regional alliance inflator factors. The computation includes provision for "a method for adjusting the regional alliance inflator factor for each regional alliance in order to reflect material changes in the demographic characteristics . . . and health status of regional alliance eligible individuals residing in the alliance area in comparison with the average change in such characteristics for such individuals residing in the United States".<sup>1</sup> Ideally, if an inflator factor is used, a risk assessment mechanism will be used to make this adjustment.

Finally, risk adjustment is also necessary to perform outcome measurement to compare provider efficiency and quality.

Each of these uses of risk assessment has different objectives and places different requirements on the risk assessment and risk adjustment. For example, when provider efficiency and quality are compared, it is likely that a method that uses prior history will be required. This is not the case for the risk adjustment mechanism that will be designed to make risk transfers among health plans within a health alliance where the objective is quite different and the transfers between health plans should balance to zero over the entire regional alliance.

One should not necessarily try to accomplish all three of the sets of objectives using the same risk assessment models and adjustment methods. Each area requires separate study. In addition, great caution should be exercised in attempting to use a single risk adjustment mechanism to accomplish multiple purposes. It is suggested in the President's proposal that the risk transfers among health plans be used to reward insurers that more aggressively cover low-income individuals. Risk adjustment mechanisms are untested for serving that role, and using a single mechanism to accomplish multiple purposes could distort transfers among plans in ways that could lead to undesirable secondary repercussions. The Academy work group advises that great caution be used in tampering with a mechanism that is so central to producing the financial incentives upon which the gains of managed competition rely.

Because the regional alliance inflator factor is such a critical area and involves complex actuarial issues, the Academy has created a separate work group that is working on its specialized issues. The group will share its separate findings with this Subcommittee. This Academy work group's comments are limited here to risk transfers among plans within a single health alliance.

#### INITIAL IMPLEMENTATION AND DESIGN ISSUES

There are two paramount concerns in developing an effective risk adjustment mechanism. First, the risk assessment measurement must be designed in a manner that avoids systematic understatement or overstatement of the risk associated with one or more of the factors used. Any systematic bias will result in transfers that distort premium differentials so that they are a less true representation of the differences in cost and effectiveness of care being delivered under different health plans. Such bias will also encourage insurers (and perhaps their providers) to do business in a way that takes advantage of that bias, thus exaggerating the extent to which premiums do not represent differences in the cost and effectiveness of care.

The second major criterion for a risk adjustment mechanism is that it be designed to prevent the providers from influencing the measurement by the course of care they deliver or by how they record an episode of care.

A close corollary to these first two criteria is that the data requirements for assessing risks not be unduly complex and that the adjustment methodology for making transfers be reasonably simple to administer. This is important to prevent unknown biases from creeping into the system, to limit the potential for individual insurers to manipulate the system and to avoid introducing even greater uncertainty into insurers' premium setting than the system will initially generate for other reasons.

Finally, risk adjustment should be prospective to the maximum extent possible to minimize uncertainty when insurers are setting their premiums. Prospective adjustment means that the factors used in the risk assessment must be readily available and up-to-date.

Meeting the goal of administrative simplicity will be more difficult to achieve than many may suppose. Even if a fairly simple system based on demographic adjustments plus one or two other factors were adopted, there would be complexities that would require trade-offs between accuracy in risk assessment and administrative cost. For example, there may be a need for different

demographic factors for each plan design contained in the Health Security Act because medical experience by age may differ for plan designs that contain different deductibles and coinsurance features. At present, some insurance companies do not maintain data on the individuals insured, particularly for employer groups of more than 25 employees. Such employers often submit a census data statement to the insurance company that just indicates the number of individual and family units to be insured. New data requirements would be necessary for the insurance companies. (It should be noted that carriers that do not maintain such data will not be able to effectively review measurements for the purpose of managing care.)

The Act recognizes that it may not be possible to develop an "adequate system of prospective adjustment of payment to health plans to account for the health status of individuals enrolled by regional alliance health plans"<sup>2</sup> or to implement such a system, and thus provides for a "mandatory reinsurance system"<sup>2</sup> which may be phased out over time as adequate prospective payment systems become available.

The Academy work group agrees with the language of the President's proposed act. In fact, in its own report on risk adjustment the Academy work group recommended that if a solution is needed in the short term, defined as the next 18 months, that a "non-voluntary reinsurance mechanism such as a high-cost medical condition system, with appropriate incentives for efficiently managing care be used as an interim measure . . . this mechanism will permit immediate movement toward risk adjustment without the need to build up complicated systems and procedures that may have to be discarded once a better long-term approach to risk adjustment has been determined".<sup>3</sup>

However, a reinsurance mechanism raises other concerns. Such a mechanism will also have to be very carefully designed to avoid rewarding inefficiency. The mechanism will need to be designed in a way that avoids encouraging more treatment than necessary because of the reimbursement feature of the reinsurance mechanism.

#### POSSIBLE SHORT-RUN APPROACH

In its May 1993 report on health risk adjustment, the Academy could not recommend that any of the current risk adjustment methods under development be adopted for purposes such as those in the proposed Health Security Act of 1993. If an interim solution is needed, however, the Academy work group would propose that a mechanism similar to the one recently implemented in New York State be considered.

The State of New York passed insurance reform legislation (Small Group and Individual Insurance Reform, Chapter 501 of the Laws of 1992 and regulations NYCRR 360 and 361) that took effect April 1993. The law has a prospective risk adjustment mechanism which depends on age, sex, and family status. There is also a mandatory reinsurance mechanism for high-cost medical conditions. The types of conditions reimbursed through the high-cost medical condition reinsurance include: heart, liver, pancreas, pulmonary and bone marrow transplantation; and intensive care for neonates with low birth weight for more than 30 days. In addition, monthly payments are made for conditions such as AIDS, and specified conditions requiring ventilator dependency.

The methodology in the New York legislation tries to discourage unnecessary treatment by setting the reimbursement equal to the lesser of a fixed amount and the actual expenses incurred, where the fixed amount is low enough to encourage the management of care; i.e., carriers cannot profit from the pool, but rather will, in most cases, have some continuing financial responsibility and incentive to manage care.



It is too soon to judge how well the New York risk adjustment methodology is working. There were predictions that many carriers would stop writing business in New York State, and in fact only a limited number did. None of the major carriers in the market has yet left the state. The Academy's Risk Adjustment Work Group has initiated a project to study the New York experience as data become available.

The New York model would require some modification before it could be adopted at the federal level. For example, the regulation requires insurers that will prospectively receive positive adjustments through the risk adjustment mechanism to build these adjustments into rates in the form of rate decreases. There is, however, no parallel requirement to increase rates for insurers that will make payouts on a prospective basis.

## CONCLUSION

Risk adjustment mechanisms are necessary in the context of a reformed system as defined by the Health Security Act. Risk adjustment mechanisms will do the following in a managed competition environment: enable relative comparisons of quality and efficiency of providers; accommodate adjustments for changing regional differences in morbidity over time; and adjust within a regional alliance for differences in the risks insured by each participating health plan so that premiums reflect differences in the effectiveness of care rather than differences in risks.

The Health Security Act contains a provision for a risk adjustment mechanism for transfers among plans within a health alliance that states a workable solution can be found April 1, 1995. The Academy agrees with that statement. The American Academy of Actuaries and the Society of Actuaries will do all that we can to help in the development of this solution.

<sup>1</sup> Health Security Act - Section 6001

<sup>2</sup> Health Security Act - Section 1541

<sup>3</sup> American Academy of Actuaries Risk Adjustment Work Group paper:  
Health Risk Assessment and Health Risk Adjustment -- Crucial Elements in Effective  
Health Care Reform - Page 2

Chairman STARK. Have any employers offered marketing programs to effect the selection by their employees?

Ms. ROSENBLATT. I think sometimes the health plans that they are using may employ marketing programs that adversely affect selection. There might be ads showing people using health clubs and things like that.

Chairman STARK. Dr. Anderson.

**STATEMENT OF GERARD F. ANDERSON, PH.D., DIRECTOR,  
JOHNS HOPKINS CENTER FOR HOSPITAL FINANCE AND  
MANAGEMENT**

Mr. ANDERSON. I am glad to testify today. I testified 3 years ago in front of you, talking about risk adjustments with respect to the Medicare program.

Chairman STARK. Are you using the same testimony that you used 3 years ago?

Mr. ANDERSON. No, it is a little bit different. It is less technical. It is a little broader picture. I have been working 10 years on this. I have new grants from HCFA, Robert Wood Johnson Foundation and the National Association for Childrens Hospitals.

Chairman STARK. What did HCFA ask you to do?

Mr. ANDERSON. We are doing some of the things that Dr. Lubitz is trying to do, risk adjustments for the Medicare program. We are trying to do the next generation of risk adjusters. It is a project we began in July of this year and it will run for 2 years.

I hate to be the classic researcher here, but the bottom line is that a lot more research and a lot more evaluation is necessary before this stuff is ready for prime time.

Basically, age and gender will result in bias selection. Almost every study we have seen suggested that it explains relatively little, and the researchers are seldom in agreement but they agree on that fact.

The reinsurance issue really has not been evaluated. What is going on in New York just started in April of this year. We don't know how it is working. If it is going to work at all, it has to be a long list of services. It has to cover most of the chronic illnesses in order to work. New York has only 14 or 15 illnesses. If it is going to be that long a list, it is going to be very close to risk adjusters. Reinsurance doesn't have any incentives for efficiency, to be an efficient provider of those expensive types of activities.

The next generation of risk adjusters have not been developed. There are no Federal studies that I know of on the under-65 population, which is who is going to be enrolled under the Clinton health plan. All the work that we have done is in the over-65 population. There is no guarantee that what we are doing for the over-65 will be applicable to the under-65, certainly not to children. So we are concerned about that.

The demonstration that the Federal Government sponsored about risk adjusters for the Medicare program basically was aborted when the HMOs didn't want to participate any longer because they knew they were getting favorable selection. The bottom line here is with 5 years and several million dollars, once this money starts flowing, we might have something for you, but we don't have anything for you currently.

In terms of analogy, one of the things I did before going to Johns Hopkins was to work on the prospective payment system. If we came to you in 1982 and said we are going to design a hospital payment system for the Medicare program and what we can adjust for is age and gender, you would have probably told us to go back to the drawing board and wait until DRGs or something like that is developed. Effectively, that is where we are today.

Now, this is a very technical and difficult issue and probably has received relatively little attention. But there is a growing concern among academic medical centers, children's hospitals, rehabilitation hospitals, psychiatric hospitals that without adequate risk adjustment they and the chronically ill patients which they treat are in very serious jeopardy.

Saturday I spent about 30 minutes briefing the trustees of Johns Hopkins University, the president of the university, the dean of the medical school, the head of the hospital. Tuesday and Wednesday of last week I was down at Duke effectively doing the same thing. They are starting to realize what are the issues.

The facts that I basically tell them is 1 percent of the people, 30 percent of health care spending, 10 percent of the people, 72 percent of health care spending, high utilization in 1 year, high utilization the next year. There is a lot of chronic illness out there. The chronically ill, as you mentioned, stay with their provider.

The academic medical centers and all those associated providers are the institutions that have historically treated the chronically ill and they are concerned that they will continue to treat the chronically ill. There is a potential for serious, serious selection bias.

Now, how will they do this? It is not very hard. It is a different type of medical underwriting than has occurred before.

One thing the academic medical centers and all the other hospitals are concerned about is that the health plan will have relatively few specialists involved. If you don't have very many infectious disease physicians, you don't get AIDS patients. If you have very few endocrinologists, you don't get diabetics. If you don't have very many pediatric oncologists, you don't get kids who have had cancer. And either patients won't enroll or if they enroll, they will disenroll.

The bottom line here is that the people with chronic conditions are going to have a fairly poor choice in many cases. They can choose a low-cost health plan that doesn't really want them. They can choose a low-cost health plan and use point-of-service options quite dramatically, is what we heard about today, that they will potentially have that option, but they will have to pay a lot more for that option.

The third thing is that they can choose the high-cost health plan, the fee-for-service option. That will get only the sick people enrolled in it and it will result in what an actuary or insurance person calls the death spiral, sicker and sicker people enrolling, willing to pay that higher cost until it effectively goes out of business.

In summary, without adequate risk adjusters, the chronically ill patients and the institutions which treat them will suffer as health plans look for good risks. I guess I am more optimistic that we will have adequate risk adjusters in 5 years if we start research now. The unfortunate thing is we have not started the research on a cross-section of the American public yet.

[The prepared statement follows:]

**TESTIMONY OF GERALD F. ANDERSON, PH.D., DIRECTOR  
JOHNS HOPKINS CENTER FOR HOSPITAL FINANCE AND MANAGEMENT**

Mr. Chairman, members of the Committee, my name is Gerard Anderson. I am Director of the Johns Hopkins Center for Hospital Finance and Management, Co-Director of the Johns Hopkins Program for Medical Technology and Practice Assessment, and an Associate Professor in the Department of Health Policy and Management at Johns Hopkins University.

Today I would like to discuss the role that risk adjusters play in health care reform and the problems that could occur if they are not properly calculated. Very simply, risk adjusters will be used to redistribute dollars among health plans based on the health status of the enrolled population in each plan. They will not be used to alter the amount a specific individual will pay. It is possible that millions or even billions of dollars will be redistributed based on risk adjusters. Their major importance, however, will not be the redistribution of dollars, but the impact that inadequate risk adjusters could have on individuals with chronic illness and the providers who treat them.

Without adequate risk adjusters, chronically ill patients are likely to suffer under Clinton's health care proposal. The proposal seeks to ensure that the chronically ill will have the opportunity to enroll in any health plan - a right which is guaranteed by explicit provisions in the law that would assure open enrollment, universal coverage and elimination of exclusions for pre-existing conditions. However, these provisions alone are not likely to stop the risk selection that is rampant in today's health insurance system.

Without adequate risk adjustment methods, chronically ill patients are likely to be shunned by health plans because they will increase the health plan's costs. Studies of the distribution of health care spending show that one percent of the population is responsible for thirty percent of total health care spending, and ten percent is responsible for seventy-two percent of spending in any given year. While some of these individuals have acute non-recurring illnesses, many of them have chronic illnesses which require costly medical care for many years. If health plans are able to maximize profits by avoiding these high cost patients, it is likely that many of them will try to do so. Without adequate risk adjusters, health plans will have a strong financial incentive to enroll the fifty percent of the population which uses only three percent of the health care resources in any given year. Health plans could use many of the same tricks that medical underwriters have used for years to exclude chronically ill populations.

One way in which health plans could discourage the enrollment of the chronically ill is to exclude those providers who are best able to care for these patients. Studies have shown that individuals who have an established relationship with their provider are the most resistant to change providers. Therefore, in the short run, most individuals with chronic illnesses are likely to continue seeing their current provider.

As a result, academic medical centers, children's hospitals and other specialty providers are likely to have difficulty joining a health plan even if they can provide services at a competitive price. Health plans will manipulate the selection of providers as a means to discourage the chronically ill from enrolling and then, to encourage them to disenroll. For example, if a plan does not have an adequate number of infectious disease specialists, patients with AIDS are unlikely to enroll; without an adequate number of endocrinologists, patients with diabetes are unlikely to enroll; and without an adequate number of pediatric oncologists, parents of children with cancer are unlikely to enroll. People who develop these illnesses are likely to disenroll if a plan does not offer adequate specialty care. While it is theoretically possible to regulate the number of physician specialties that each health plan must have, this would require an intrusive regulatory apparatus.

Providers who already concentrate on caring for the chronically ill have the option of forming their own health plan. Under this scenario, a health plan that includes academic health centers, children's hospitals, and other specialty hospitals is likely to attract individuals with chronic illnesses. Since their health care costs are likely to be significantly higher than that of the average person, this health plan will need to charge a higher price. The higher price is likely to discourage some relatively healthy people who want access to these institutions in the unlikely event that they develop a serious illness. Because a sicker than average population is more expensive to cover, the health plan will need to charge a higher price in the following year to reflect the still higher proportion of enrollees with chronic illnesses. This could continue for several years until the health plan enters a "death spiral" in which the price that must be charged is so high that only a small number of people will be willing to pay that higher price.

Another possibility is that health plans will choose to contract with a specialty provider in a different geographic location if the health plan is able to obtain a better price for specialty care. In this case, patients needing specialty referrals may be forced to travel far from home and remain far from social support networks. This would be another, more subtle, mechanism used by health plans to discourage the enrollment of high risk people.

Inadequate risk adjusters could also increase the price that individuals with chronic illnesses will have to pay. While the Clinton plan assures access to health care for all people regardless of health status, it does not guarantee access at an affordable price. Without adequate risk adjusters, individual's with chronic illness will have a choice: they can join a plan that charges a lower price, although it may not provide access to the providers best able to care for their clinical condition, or they may choose the higher priced plan and pay more out of pocket.

### Solution

Adequate risk adjusters are needed to help alleviate many of the problems associated with a competitive health care market place. If the adjustments were appropriate, then patients with chronic illness would be welcomed by all health plans and health plans could compete on the basis of price, quality of care, access and other relevant factors.

Unfortunately, risk adjusters are still being developed and adequate risk adjusters are at least several years away. Most of the risk adjustment methods currently in place are based primarily on age and gender. These are simply inadequate to prevent the types of behavior that are likely to occur as health plans look to enroll healthy people.

Implementing a risk adjustment mechanism based only on age and gender is equivalent to implementing a per case hospital payment system such as Medicare PPS without an adequate case-mix measure. If the Administration had proposed a reform of the Medicare hospital payment system to adjust payment rates to hospitals only for age and gender, it would have been obvious that some type of case-mix classification system was necessary. If the Administration had been told that it would take several years until a DRG type case-mix system could be developed, the Congress probably would have told the Administration to come back after a viable case-mix measure was developed. Unfortunately, the Administration is making just this type of argument for risk adjusters.

I would be more optimistic that adequate risk adjusters could be developed if there was more research underway. I am aware of no major research projects using data from a cross-section of the American public to develop a new generation of risk adjusters. I am currently working on a project to develop a new risk adjustment methodology for the Medicare population as part of a HCFA contract. Our current project focuses exclusively on the elderly. While it is possible to adapt our methodology to the under 65 population, it would be a major undertaking.

One refinement under discussion is reinsurance or a risk pool for individuals who incur expenses exceeding a threshold amount in a given year. New York State implemented a reinsurance pool for 15 specific diseases in April 1993. No one has evaluated its impact. It is likely that this limited reinsurance pool would be inadequate to prevent discrimination against individuals with a wide range of chronic illnesses unless the reinsurance pool covers most chronic illnesses. This essentially would be a risk adjustment system.

I know that academicians are accused of ending every paper with "more research on this topic is necessary", but in this instance, it is really the case. The research on risk adjusters should cover the entire range of the population and the research team should include a broad spectrum of providers to make sure that both the clinical and operational issues are addressed. It will take several years for the research to be completed once it is funded.

I would be happy to discuss specific risk adjustment methods that are under development or answer any questions that you may have.

Chairman STARK. Dr. Luft, we are going to spare you for about 10 minutes while we vote and we will come back and let you have wrap this up for us. Excuse us.

[Recess.]

**STATEMENT OF HAROLD S. LUFT, PH.D., PROFESSOR OF HEALTH ECONOMICS, ACTING DIRECTOR, INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO**

Chairman STARK. Mr. Luft.

Mr. LUFT. Mr. Chairman, I appreciate the opportunity to testify before this subcommittee, I have spent almost 20 years studying HMOs and about 10 years working on issues of bias selection and risk adjustment methodologies. My perspective is that of a researcher and also as one who has served on the University of California committee dealing with health insurance, specifically health insurance plans for the faculty.

Differences in risk are a natural consequence of any situation in which individuals have some kind of choice. People differ in their genetic risk factors, their environmental history, personal preferences, et cetera. People may choose particular health plans for varying reasons, some of which may be related to risk for good and important reasons for themselves. Likewise, plans may seek to either attract or avoid certain kinds of risks.

You have heard already that predicting medical care expenditures are extraordinarily difficult. A very small fraction of the population, approximately 1 percent, accounts for 30 percent of all medical costs. And the models that we health service researchers use typically explain only a small fraction of the variability, when we are looking at individuals or families.

If we group people together randomly, it is possible to explain more of the variability because many factors affecting medical care use just random events. But more realistically, if we have non-random selection, which is obviously the issue that we are looking at since if everybody were randomly assigned to health plans, we wouldn't be having these hearings, the explanatory power improves and we can explain more of the differences in risk.

But this is precisely the kind of situation in which risk adjustment can work moderately well, a situation in which there is no aggressive selection by the health plans. What we are talking about here, for example, is would we be able to develop a risk-adjusted payment by, let's say, corporations that wanted to be in or out of a corporate alliance, or that wanted to be in or out of a health alliance? I would argue that that could probably be done reasonably well, largely because employers hire workers because of particular skills, not because they have high or low medical risk. That they are not selecting people based upon their health risk.

Chairman STARK. You don't think that ever happens?

Mr. LUFT. It happens occasionally.

Chairman STARK. You don't think that employers specifically avoid certain classes?

Mr. LUFT. I think it certainly can happen for small employers.

Chairman STARK. How about the big ones? No.

Mr. LUFT. With large employers it happens occasionally, but I think we can probably detect that with the measures available.

Chairman STARK. OK.

Mr. LUFT. I don't want to put a lot of money on that, but I don't think there is a lot of money to lose one way or the other in that situation.

Chairman STARK. Get to know Mr. Lubitz. He is going to get an increase in pay.

Mr. LUBITZ. That is the fourth time you said that.

Mr. LUFT. And it is all down in the record.

It is a different problem when we are talking about paying health plans. There the small number of high-cost people really are the issue, and there are a whole series of techniques that health plans might use to avoid covering those individuals. Some of those techniques could be active or direct measures.

In fact, I became interested in examining this issue when we found at the University of California that one of the HMOs was routinely losing enrollment forms for single men living in the Castro District, where there is a high proportion of gay men.

Chairman STARK. Bad mail service there.

Mr. LUFT. That is right. That led me to start thinking about how we could resolve that problem other than telling them they shouldn't do it. You can affect enrollment through the location of clinics, or the subtle messages that might occur in advertisements, as you pointed out.

Other factors affecting selection—favorable or adverse—might be passive or accidental. The reputations of the physicians who happen to be in the plan or their practice styles or the location of where the clinic facilities happen to be. I think it is almost impossible to develop models that would capture all the risk.

What that means is, if we try to set up models to set risk-adjusted payments externally, we will have a continuous game of setting the rules with enormous incentives by the health plans to figure out how to beat those rules. It is a fun game that will employ a lot of consultants, but I don't think it will work.

The current HCFA model for paying HMOs is essentially a formula-based capitation model, and they are stuck with the legislation that they are working under. If selection occurs within categories, there is a constant test of expertise between the plans and HCFA, and the problem is that not all HMOs have favorable selection. Some have adverse selection, so it is very difficult to come up with a formula that works fairly for all plans.

I think in the context of the health alliances, the situation might be quite a bit different. First of all, there are a number of things that will reduce risk selection, such as the uniform benefits. More importantly, if we think of the health alliance as encompassing all the risk in the area, which in essence they would, then if a health plan is dumping high-risk patients on somebody else, the other health plan that gets those patients will know it. It is in their interest to find that out very quickly and they will be able to identify those cases.

If the health alliance sets up a mechanism whereby those health plans can demonstrate that they have more HIV cases, more kids with cystic fibrosis, et cetera, then they can estimate what the



costs would be and develop payment mechanisms to deal with those high-cost cases.

Once that is done, I think the relatively large fraction of the population that doesn't account for very much in the way of costs can be dealt with through other measures such as demographic factors.

The advantage of using this kind of approach, rather than just a reinsurance pool, is that it focuses on diagnoses. It focuses on identifying patients and it encourages the health plans to try to figure out how to improve delivery and quality of care since it would be possible to review available medical records. Health plans could be paid on something like a DRG basis, although payment should be on a monthly basis to make sure they keep people alive.

The ability to review medical records could feed back into the quality assurance mechanism. Thus, I would argue, that a risk adjustment process would lead us in a better path than just a reinsurance pool. I would be happy to take any questions.

[The prepared statement and attachment follow:]

TESTIMONY OF HAROLD S. LUFT  
ACTING DIRECTOR  
INSTITUTE FOR HEALTH POLICY STUDIES

Risk Adjustments for Differences in Enrollee Mix in Health Plans

Harold S. Luft, Ph.D.

Thank you, Mr. Chairman, for the opportunity to testify on an issue which will be critical to the success or failure of any health care plan. As long as people are offered a choice of provider systems, whether they are HMOs or other types of insurance plans which accept risk, one must have methods to assess and adjust for risk differences among plans. Single payer public programs, such as Medicare or Medicaid, which contract with delivery systems likewise have the need to risk adjust their payments. Employers offering options to their employees to enroll in various health plans need to assess whether there is fair compensation of the plans. In fact, unless everyone is forced to be in a unitary fee-for-service plan, or is randomly assigned to a plan, there will be a need for risk adjustment. Even in such an environment, risk adjustment in the payments offered providers will be required, much as is the intent of the Diagnosis Related Groups used by Medicare in its payments to hospitals.

Differences in risk arise from the variability in genetic predisposition to illness, socioeconomic and environmental factors, and personal preferences. These differences affect the need for medical care and the costs associated with different individuals. In the absence of random assignment into accountable health plans, people will often select plans according to their expectation of need for care, for instance because of a chronic illness. This will mean that persons with complex illnesses, with established patient-physician (or institution) relationships, will likely opt for plans that include centers of high specialization. On the other hand, persons in generally good health will likely select plans offering the most convenient access to preventive, "well baby," and primary care. The resultant enrollments into plans will produce groups of subscribers with substantially different health characteristics and thus per capita costs. If health care plans and providers are paid the same amount without respect to risk differences, they will tend to avoid those people at greater risk and seek to attract those at lesser risk. To assure that all people have equal access irrespective of their risk, it is necessary that risk be measured and payments be adjusted to reflect risk differences. However, there is no need to make individuals bear the financial consequences of their risk differences. That is, all enrollees or individuals may pay the same community-rated premium or tax rate irrespective of their risk as long as their sponsor (employer or government) provides risk-adjusted payments to the health plans.

Within this general framework concerning risk-adjustment, there are several key issues I would like to bring before the Committee. The first is the ability of various risk assessment models to predict medical expenditures. The second is the distinction between risk adjustments for employee groups vs. risk adjustment payments to health plans. The third is the process used to generate the risk adjustments.

## Predicting Medical Expenditures

The basic goal of risk assessment is the prediction of future medical care expenditures. When one thinks about medical care use, some types of use are fairly predictable, such as periodic checkups and treatment for the occasional winter cold. Other types of medical care are predictable if one knows something about the individual, such as the need for maternity care for a couple wishing to have a child, or the periodic visits of a diabetic.

The more expensive types of medical care, including extensive hospitalization and repeated outpatient tests and procedures, however, are far less predictable. Even knowing that someone has a family history of cancer or heart disease merely leads to the expectation that their medical care costs will tend to be above average, but it is still almost impossible to predict with any accuracy whether their expenditures will be \$1500, \$15,000, or \$150,000 next year. For example, the top 1% of the population in terms of expenditures accounts for 30% of all medical care costs and the bottom 50% accounts for only 3% of costs (Berk and Monheit, 1992).

Economists and health services researchers typically have attempted to estimate models that predict future medical care expenditures on the basis of various enrollee characteristics. The predictive factors include demographic variables such as age and gender, socioeconomic variables such as education and income, health and functional status, and prior medical care use. The models are usually assessed on the basis of the  $R^2$  or the proportion of the variability in expenditures which can be "explained" using the various risk factors. Typically, as one adds variables more closely associated with health status and prior use, the higher the  $R^2$ , but it is unusual to be able to explain even as much as 10% of the variation in expenditures.

These low  $R^2$  values are taken by some as an indication of the impossibility of developing a practical risk adjustment mechanism. These critics point out that the "better" methods often require substantial data collection efforts to capture information on patient health status and even with such data the vast majority of the variance is left unexplained.

There are several reasons for these low values. One is that the distribution of medical care expenditures is highly skewed. For example, in a data set composed of 5000 Bank of America employees and their families with fee-for-service coverage, 16.7% of the subscriber units had no expenditures during the year, 71.0% had only ambulatory expenditures with an average cost of \$1557, and 12.3% had one or more hospital episodes with total costs averaging \$15,149 (Table 1). Of these, 49 had total costs of \$50,000 or more. Even with fairly complex models designed to deal with such skewed distributions, the lowest predicted expenditures given by our model was \$631, and the highest was \$11,044 (Rosenkranz and Luft, 1993). Advances in modeling techniques will be needed to better approximate the skewed distribution of medical care expenditures.

The second reason one should not expect to be able to "explain" all the variability in medical expenditures is that some expenditures are inherently unpredictable. The random automobile accident is an extreme example. Even if one can tell that someone is at very high risk of having a heart attack, it is impossible to predict the event with certainty, let alone determine whether the patient will die in his sleep at home or be resuscitated and undergo expensive medical interventions.

Given that perfect, or even moderately high, explanatory power is unachievable, should we despair of having a usable risk adjustment methodology? I think not, because the ability to predict the medical care use of an individual may not be necessary to accomplish the required functions of risk adjustment. While the casinos in Las Vegas are unable to predict the roll of the dice, they do know that on average the odds will be in their favor. Likewise, life and health insurance companies do not need to know the likely expenditures of each enrollee if they are able to predict well for groups. (Obviously, it would be even better if they could predict individual expenditures well, but this may not be necessary.)

To provide a sense of the importance of grouping, we used our data on the 5000 subscriber units (single and family enrollees) in the Bank of America data set. Figure 1 shows that for subscriber units our predicted expenditures range from roughly \$650 to \$11,000 and the actual expenditures, ranging from \$0 to \$50,000, bear little relation to the predicted. If we aggregate subscribers randomly into 100 groups of 50 (Figure 2), two major changes are apparent. The average actual cost varies far less across groups of 50; the range is roughly from \$1200 per unit to \$6100. Unfortunately, the same averaging process reduces the spread in the predicted expenditures, so the risk adjustment provides little information.

It is important to note, however, that the random aggregation is expected to "wash out" consistent patterns. In fact, if people were randomly assigned to health plans, we would not need risk adjustment, although plans with small numbers of enrollees might want to reinsure against the small probability they enrolled an unusually expensive set of patients.

To provide a sense of what risk factors can do if people are selected on the basis of risk, we then ordered the 5000 cases by their predicted expenditures and created a new set of 100 groups designed to be as similar as possible with respect to their predicted expenses. As can be seen in Figure 3, the spread in average predicted cost across these groups is much greater (roughly \$850 to \$8000) and more importantly, the pattern of actual cost is quite similar. In fact, the  $R^2$  across these groups is .703, indicating that 70% of the variation in expenditures at a group level can be explained by a fairly simple demographic and employee characteristics model. (In contrast, the  $R^2$  for the randomly selected groups is only .13).

The message from this exercise is that concern about the poor explanatory power of models focusing on individual expenditures is misplaced if the real issue is how well one can predict for groups, particularly groups reflecting non-random risk-related selection. In fact, it is precisely such situations in which risk adjustment is needed.

### **Risk Adjustments for Employee Groups vs. Health Plans**

The risk assessment methodologies can be applied in various settings, but their most frequent uses are to assess the risk of (1) various employee or population groups and (2) groups of enrollees in various health plans. While the analytic techniques are similar, the two situations place markedly different requirements on the accuracy of the risk assessments.

In the first situation, one is examining the risk associated with all the employees in a company or union, or all Medicare beneficiaries in a geographic area. It is certainly the case that employers may have workforces which differ substantially by age, gender, and other factors likely to influence medical care use. For example, even with the same benefit package, the expected costs for McDonald's employees will be far lower than the costs for Chrysler employees.

The Administration's health reform proposal envisions community rating within each regional Health Alliance. This means that each employer in the region would have to contribute the same minimum amount, irrespective of the composition of its workforce. (This ignores the role of subsidies for small employers or the cap on premium contributions as a percentage of payroll.) Large employers with 5000 or more employees would have the option of establishing their own Corporate Alliances. One of the principal reasons a firm might choose to do so is if its employee pool would be expected to incur substantially lower medical care costs than the pool of enrollees in the regional Health Alliance. To determine whether this is the case, the firm will have to rely on its own risk assessment and compare its likely costs with the costs under the Health Alliance.

Those firms initially choosing to establish their own Corporate Alliances and later wanting to join a regional Health Alliance will have to pay a risk-adjusted contribution to the Health Alliance. This is only fair since it is likely that the "change of heart" reflects the realization that their own health care costs have risen above what they would be if the firm were in the Health Alliance. Thus, there will need to be a mechanism for assessing risk at the employer level.

Fortunately, most firms hire workers for reasons other than their expected medical care use. This will be even more true under the Administration's proposal which aggregates small firms into the regional Health Alliances. Thus, it is likely that the relatively simple demographic models used both by researchers and actuaries will be sufficient to assess differences in health risk among the large firms able to choose between being in or out of the regional Health Alliances.

The situation is quite different when one is assessing risk differences across health plans contracting with either a Health Alliance or an employer. In such cases, one wants to know whether those people choosing a specific health plan are at lower or higher risk than average so that payments to those health plans can be adjusted accordingly. Unlike the previous situation, people are likely to choose their health plans based on factors related to their expected use of medical care. This is one of the reasons why the uniform benefit packages incorporated in the Administration's proposal are so crucial. For example, without such uniformity, a health plan could

avoid diabetics by not covering outpatient drugs or injectables; it could avoid patients with infertility problems by not covering such services; and it could avoid the mentally ill by offering minimal mental health benefits. Benefit design could also be used to attract relatively low-risk people. For example, covering immunizations and pediatric visits would tend to attract relatively young families.

Even with uniform benefits, health plans could still attempt to avoid certain types of high-cost enrollees. The University of California, San Francisco, had a health plan which tended to "accidentally" lose the enrollment forms of employees who happened to be single males living in zip code areas in the city favored by the gay population. Other schemes can be even more subtle and should probably not be noted lest they be applied by plans not already attempting to use them. However, even without active efforts to "dump" high-cost enrollees, both favorable and adverse selection are likely to occur just by chance. For example, a health plan which is affiliated with a high-quality subspecialty group or a medical school may attract people with serious medical problems. Likewise, health plans with clinic facilities in the inner city may attract a disproportionate share of high-risk, low-income enrollees. Thus, risk assessment approaches for paying health plans will have to be able to address the problems associated with enrollee selection focused on medical problems.

When health plan choice may be influenced by the presence of specific conditions or the need for specific expensive procedures, we are forced to ask whether it is possible to predict such needs. It is important to remember that in these situations we are often concerned about a relatively small number of people with quite substantial medical care costs. This makes it difficult to estimate and apply econometric or other models. While some models may be able to differentiate people at high vs. low risk of needing selected services, they will never be able to offset biased selection in the face of the subtle factors likely to be present in the "real world." Shifting the focus from a "search for the perfect model" to a "process for risk adjustment" may be a better solution.

### **Risk Adjustment Processes**

It is one thing to attempt to assess differences in risk. It is quite another to discuss the ways in which payments are adjusted to offset differences in risk. One way, which is used by HCFA in paying HMOs under risk-based contracts, might be termed the open-ended, formula-based approach. HCFA has determined that the payment to HMOs will be based on 95% of its estimate of the cost of Medicare beneficiaries in fee-for-service in the local area. This estimate is based on demographic factors (age, gender, institutional, and disability status) with an adjustment for county cost and utilization patterns. With this formula, it is possible for a potential contractor to know with reasonable certainty what its premium will be for each enrollee. If it feels the premiums are too low, perhaps because the average fee-for-service use and cost patterns in the area are low, then it can choose not to contract on a risk basis and may, instead, choose cost reimbursement. Thus there is potential selection even with respect to the plans choosing to contract with HCFA; only the ones for whom the formula is favorable are likely to "enter the game."

The potential for selection is further enhanced by other "rules of the game." Enrollment is on an individual basis with no more than a 30-day lock-in. This means that the health plans have to market to individuals, thereby both increasing their costs and offering the opportunity to avoid people with serious medical problems through targeted marketing efforts. Furthermore, since new health plans often involve the selection of a new physician, people currently under care for chronic problems are more likely to either not enroll, or disenroll when they realize the need to change physicians. All of these factors are likely to lead to favorable selection which will not be captured by the HCFA formula. Numerous studies have demonstrated various degrees of selection bias, yet there is no simple way for HCFA to address this problem, particularly since some HMOs actually attract enrollees of higher than average risk.

The potential situation under a Health Alliance is quite different. With the exception of those persons excluded from coverage and those covered under the Corporate Alliances, everyone in a geographic area will be in one of the health plans in the Health Alliance. The Health Alliance will be able to serve as a neutral referee in addressing disputes among the plans as to who has adverse and who favorable selection. More importantly, the Health Alliance is essentially operating in a "zero-sum" environment. This implies that increased payments to Plan A because it has higher than average risk must be offset by lower payments to the other plans because they have lower risk.

Also, there is no reason for the Health Alliance to limit itself to prospectively based formulas. For example, suppose that it convenes a meeting of the health plans in its area and as is likely, each plan claims adverse selection. One says it has a disproportionate share of HIV-positive individuals, another claims an above average rate of children with cystic fibrosis, and a third claims an above average rate of premature babies who incur high costs in the neonatal intensive care unit. It is certainly a plausible scenario that each health plan will be able to claim adverse selection in some area.

Working with the health plans, the Health Alliance can estimate what it costs to care for each of these types of cases for a month, perhaps even adjusting payments based on CD4 count for the HIV-positive patients and size for the neonates. Since the total number of cases per year in the Health Alliance's area can be estimated with reasonable certainty, the Health Alliance can set aside that much money to pay those health plans actually taking care of these high-cost cases. The remainder of the funds can then be allocated among the health plans using more traditional methods such as age and gender.

Other "rules of the game" within the Health Alliance framework are also likely to reduce the impact of biased selection. Uniform benefit plans will eliminate the use of benefits and coverage differences to avoid certain types of patients. An annual open enrollment season in which people will be able to switch plans, but then be locked in for a year will reduce the problems of rapid turnover and individual marketing experienced in the Medicare HMO market.

Health Alliances should be allowed to design their own categories of high-risk cases and determine relative costs based on the experience in their own locality. HIV infection is a substantial problem in the San Francisco Bay Area, but it may not be an important aspect of biased selection in Little Rock. In addition, the patterns of treating HIV disease in San Francisco and New York differ markedly, so local costs are the relevant factor for adjusting payments.

The Health Alliances should be encouraged to continuously improve their risk adjustment methods. Rather than being tied to a fixed list of conditions and cost weights, the Health Alliances should ask the health plans each year whether they have experienced adverse selection above and beyond the factors already included. If so, they should bring the evidence to the table for consideration as an additional prospective or retrospective risk factor. This process will also point out if the high-cost cases are coming disproportionately from a certain health plan, providing circumstantial evidence of dumping, which may be followed up with more detailed investigation.

The model of continuous improvement of the risk adjustment process within the zero sum game of the Health Alliance has several important implications. First, unlike the current Medicare model, health plans will not have the choice of selecting the approaches, formula, or reimbursement that are best for themselves. Instead, if a health plan wishes to be offered in a geographic area, it must play by the same set of rules as all other plans in that area. Second, claims of adverse selection by health plans need not be countered by the Health Alliance. They will be countered by the other health plans because additional payments to one plan come out of the pool of funds available for the other plans. Third, the intent to refine the payments each year means that a plan attempting to cream skim can expect to do so for only a year or two before such excess profits are eliminated. Since cream skimming carries its own costs, the threat of losing that advantage may prevent such behavior from even being attempted.

The combination of prospective and retrospective payments is an attempt to compensate for the inability of all risk adjustment models to identify precisely and prospectively from routinely collected data the small number of very expensive cases. A simpler approach would be to merely establish a reinsurance pool to allow health plans to recover part or all of their costs for very high cost cases. While such an approach has the advantage of simplicity, it has several important flaws. First, it does not reward those health plans that have developed better and more cost effective ways of treating seriously ill patients. Since the funds for such a pool are implicitly taken equally from all plans, it particularly penalizes those that manage seriously ill patients well and keep their costs below the threshold of say, \$50,000.

Second, it focuses on passive collection of expense data, rather than active collection of clinical information. If health plans knew that certain conditions were selected for additional payments, they could also be required to collect ongoing information from the patients as to their health status and quality of care. In this manner, the Health Alliance could assess whether plans caring for seriously ill patients at lower cost provided comparable levels of patient outcomes and



satisfaction. As Health Alliances around the nation share their data for these high-risk cases, we could advance medical practice in terms of caring for such patients.

It is important to remember that biased selection is an inherent feature of any arrangement that allows choice. However, various arrangements and "rules of the game" can either increase or decrease the rewards available to players attempting to seek out only the favorable risks. In the context of regional Health Alliances, it should be possible to establish rules that reward those plans "playing fairly" and reduce the gains for those seeking unfair advantage. Moreover, such risk adjustment processes can be designed to focus not just on financial adjustment, but also on better ways to improve the quality of medical care.

## References

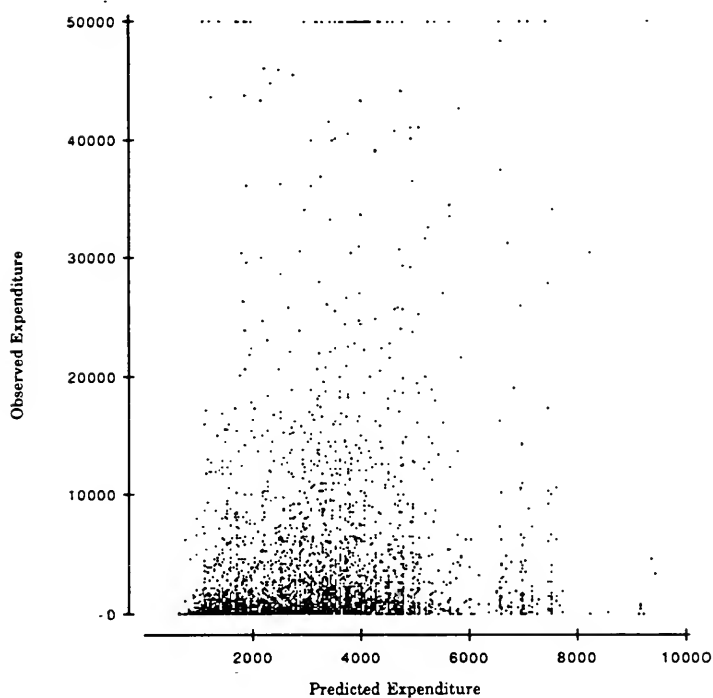
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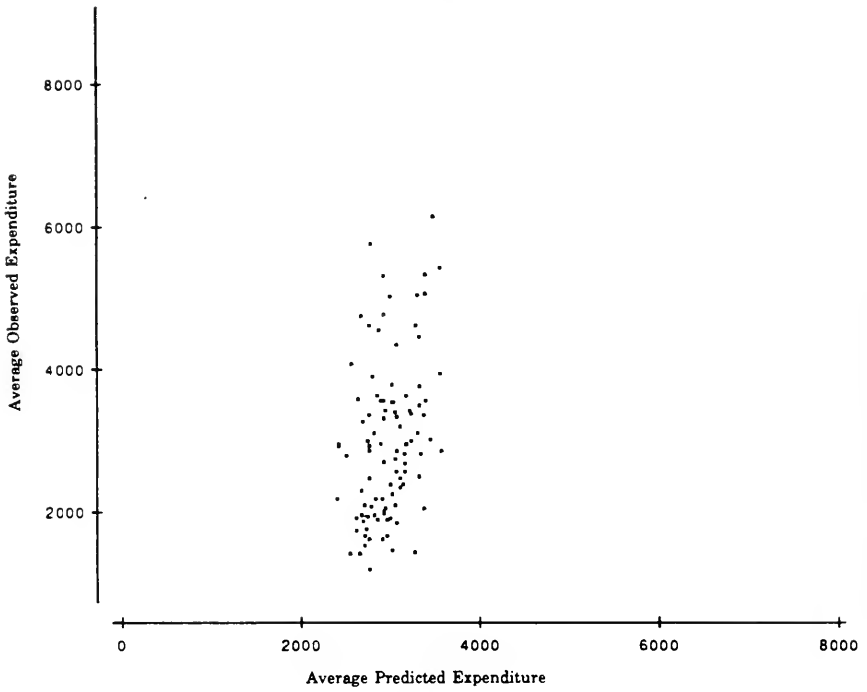
**Table 1.**  
**Expenditure Characteristics of 5000 Subscriber Units**  
**in the Bank of America Fee for Service Plan**

	<u>Number of SUs</u>	<u>Percent</u>	<u>Mean Cost</u>	<u>Median Cost</u>
No utilization	832	16.7%	\$0	\$0
Ambulatory, no inpatient	3,551	71.0%	\$1,557	\$779
Some inpatient	617	12.3%	\$15,149	\$10,902

Figure 1.  
Observed and Predicted Expenditures for 5000 Subscriber Units  
in the Bank of America Fee for Service Plan

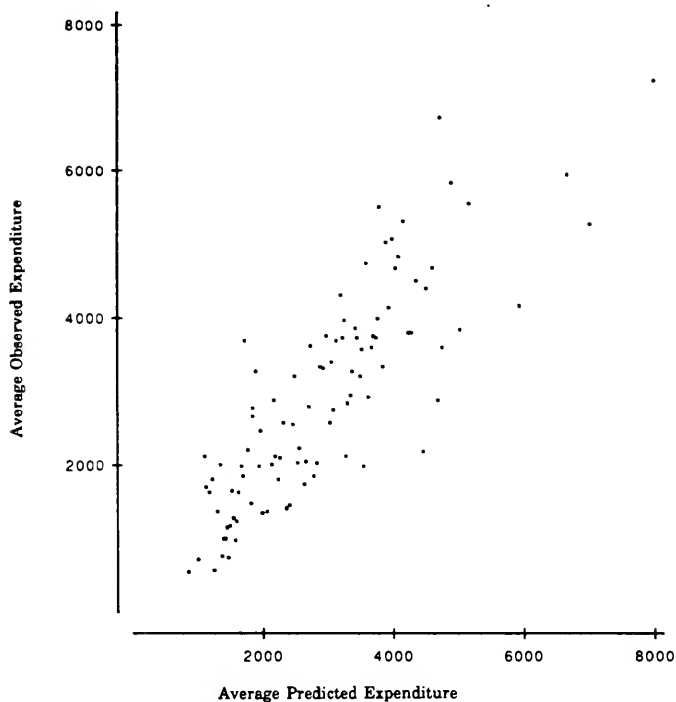


**Figure 2.**  
**Observed and Predicted Expenditures per Subscriber Unit**  
**When SUs are Randomly Assigned to Groups of 50**



**Figure 3.**

**Observed and Predicted Expenditures per Subscriber Unit  
When SUs are Assigned to Groups of 50 Based on Predicted Risk**



Chairman STARK. Let me just start out by saying that I think that, at least in my view, it is probable that we won't develop a risk development system in the foreseeable future. Everything I am hearing sounds to me like, at best, you just sit down and negotiate. You take an area like the District of Columbia, there might be 10 or 12 plans, and you would have to negotiate a different risk adjustment contract than you might have to in Montana.

It just doesn't seem to me like you have got a formula. None of you have come forth with one, and I don't really think the administration has one, so that we will, if we don't have a system that will make the health plans neutral, then how would you explain to us in layman's terms what problems would come up?

It was difficult to get the administration to say, OK, if we don't have risk adjusters, what do we do? I don't think there is the remotest chance on God's green Earth that we are going to have mandatory alliances. There haven't been three votes for it.

I haven't been able to find any witnesses that support them. The plan fails, you don't have mandatory alliances, you can still go ahead and do all the things. You take one slice of baloney out of the sandwich, you still got a baloney sandwich. So if we don't have risk adjusters, how can we make a plan that is not a single payer plan work?

Ms. Rosenblatt, what happens in Massachusetts if we don't?

Ms. ROSENBLATT. Thank you. Massachusetts is a great example. One of the problems that will happen, to answer your question, is that we are starting out with a playing field that isn't a level playing field, and in a State such as Massachusetts, State laws for certain blocks of business, such as the individual insurance market, treat the Blues plan separately than other plans in the marketplace, such as commercial carriers.

For example, in the State of Massachusetts, Blue Cross and Blue Shield of Massachusetts today has individual insurance where we are required to do community rating and act as insurer of last resort. Commercial carriers and HMOs are able for that same segment to do medical underwriting.

Chairman STARK. But now that the rules are off, what are you going to do? You have been learning from all your competitors all these years how to exclude people and how to do all these things. What is the first thing you are going to do?

Ms. ROSENBLATT. Our competitors have been doing that. We have been watching them, that is correct.

Chairman STARK. You have been watching them. One of the things you are just dying to do that they do that—

Ms. ROSENBLATT. We would like to spread around the population that we have to them and we would like to get some of the good risks that they have. There are a lot of things that we would not be permitted to do under the Health Security Act because we would have to community rate.

So we could take a big financial bet. Assume we are just insuring that block of business, because one of the things that is going to change drastically is that we are going to be combining all of these different pools. Right now we rate our individual block of business separately than our larger employer groups or small employer groups.

But if we are just looking at that pool of business, we could intentionally underprice that product and say, well, if we price it real low, we will hope to get some of those healthy people. If we don't, if they like where they are, then we are going to suffer a huge financial loss because of that pricing decision. So those are some of the things that will happen.

In an environment where there is a need for caution and conservatism, you really need to price for what you have now. It is unlikely, as you mentioned before, that everyone is going to move to other carriers.

So Blue Cross and Blue Shield, which has been the insurer of last resort, ends up at a much higher community rate than the carriers who have been able to exclude the high-risk cases in the past.

So that is just one of the things that would happen. If you don't risk adjust and you also require community rating, what I think will happen is that plans such as indemnity plans that have all of the providers will have the high risks. There maybe exceptions.

And many of those indemnity plans will go into death spirals, which was talked about earlier—

Chairman STARK. Into what?

Ms. ROSENBLATT. Into death spirals, assessment spirals, where each year the best risks leave and each year you are ending up with a worse and worse risk pool, necessitating higher and higher premium increases.

Now, if you further impose on that a premium cap so that you can't adequately reflect in your premium what the costs of those high risks are then those plans will go insolvent.

Chairman STARK. They will start to lever on their providers, the providers will quit, and then the plan becomes worse, and it just gets worse and worse?

Ms. ROSENBLATT. That is exactly correct.

Chairman STARK. Try the reverse. Let's suppose that the Federal Government, heaven forbid, steps up to the bar and offers a plan that has a minimum benefit, the same, and we sell it and we have cost controls, which we now have, but you don't; the private side doesn't, so that we will get all these indemnity plan people, but we will have a big enough base because we will have Medicare in there and the Medicaid population and anybody else who can't get insurance, we will pick up, let's say, half, but again, we have fee and DRGs so we can control our costs, and my more conservative colleagues will say we can't do that to the private side, it will stifle competition, so I say, all right, no cost controls on the private side. How would that play out in Massachusetts?

Ms. ROSENBLATT. I am not sure I exactly understand the question so I am going to take a shot at what I think the question is. If one side had tremendous bargaining power, which the government would, then I would expect that those fees or DRG payments would probably be better than any private entity would be able to obtain.

Chairman STARK. Would be lower?

Ms. ROSENBLATT. It would quite possibly be lower and therefore there would be a cost shift onto people that stayed outside of the system as opposed to—

Chairman STARK. And then what would happen to the private plan premiums?

Ms. ROSENBLATT. Private plan premium would increase.

Chairman STARK. And then what would happen the next year?

Ms. ROSENBLATT. It would depend on how the cost shift was made up.

Chairman STARK. Well, in time. As you continue—as I get the sicker and more expensive population, I can only make up for it by ratcheting down on the providers, right, which cost shifts to the private plans, right? Which raises their premium and at some point, folks are going to get smart enough to join my plan, aren't they?

Ms. ROSENBLATT. The only point that I make with respect to that is that it is very difficult to make up for risk selection through the discount mechanism because of the numbers we have been tossing around, 4 percent and the 50 percent.

In the past, many Blue Cross and Blue Shield plans in certain States were able to operate as the insurer of last resort because they had a broad enough market share and in many cases legislative discounts and were able to offset the impact of those high-risk cases. As new competition came in that was able to negotiate prices, the burden of those high-risk people was more than the value of the discount.

So I think that is one of the things that you have to think about as well.

Mr. ANDERSON. I think you have to take a look at what has happened in the Medicare program with respect to HMOs, and you have seen that the HMOs haven't taken the sick people, and they have remained in the Medicare program—

Chairman STARK. They have not taken them?

Mr. ANDERSON. They have not taken them. They have remained in the Medicare program. The Medicare program has significant adverse selection. Most of the studies suggest 25 percent adverse selection. They know who are the sick people and who not, and they are going to put those people into the Medicare-type program.

They are going to do the same thing under the Clinton proposal. You will get a price discount, but you are going to get 10 percent of the people who are going to incur 72 percent of the expenditures. And you will get a discount on it, but you will still get all the bad risks or a high percentage of them.

Chairman STARK. How much of that do you think is marketing by the plans? Dr. Luft may have studied this, so that the risk contractors are avoiding the high risk kind of Medicare population, and how much of it is just that the high-risk population in Medicare figures out that they are better off staying in the indemnity plan because of their broader choice? I don't know if that is a chicken or egg issue.

Mr. ANDERSON. I would say that it is the providers that you have access to. If you are a chronically ill person, you want to go—since I am at Johns Hopkins, you want to go to Johns Hopkins to receive your care, and if the health plan doesn't include Johns Hopkins or you have to pay an awful lot more in a point-of-service contract, you don't join that one.



So it just makes sense to me, based upon the providers, not on the benefit structure or anything else, just what providers you have access to.

Mr. LUFT. I think it is due to a combination of things. One is that we often talk about the Medicare program while forgetting about the Medicare supplemental, which is a major piece of what individuals buy. It is not a Federal program, but the HMOs bundle that together so that leads to risk selection. Then you can go in and out of the HMOs every month.

Chairman STARK. But given all of that, you don't get a very big participation in these risk contracts in Medicare.

Mr. LUFT. What we have actually is selection in terms of the plans willing to participate in the Medicare program.

Chairman STARK. It will be interesting to watch in northern California what they do.

Mr. LUFT. Traditionally, what I think they have done is look at the amount that Medicare is willing to pay based on the formula, and in some areas, like south Florida and southern California, they have been very happy to go in. In other areas like Boston, they haven't.

And yet it is the same Medicare program and there are HMOs in both areas, and so I think what we see there is that it is a combination of the plans being willing to go in, based upon what the fee-for-service payments are in that area (for example, in south Florida they are very high), and also their ability to do some risk selection within the plan.

Medicare is the 800 pound gorilla when it comes to paying fee-for-service providers, but it is not terribly nimble when it comes to dealing with HMOs.

Chairman STARK. Well, I don't think we have gotten the best price. Somehow I think we are overpaying a lot in risk contracts, but that is just—

Mr. LUFT. We need Jim to finish.

Chairman STARK. As I say, put Mr. Lubitz on commission and then we will get those prices down.

Did you want to add something, Ms. Rosenblatt?

Ms. ROSENBLATT. Yes, thank you. Since Mr. Luft mentioned the Boston situation in terms of Medicare, I just want to mention that there are some additional complicating factors.

Once again, the Medicare supplement plan that Blue Cross and Blue Shield of Massachusetts provides is a very heavily regulated product. The law treats Blue Cross and Blue Shield differently than other carriers today. We are hoping for regulations to be passed that will correct that shortly, perhaps even today. The premium is kept down through a rate preapproval process that other carriers aren't subject to, so that while the HMOs might look attractive in a true competitive environment, were the indemnity plan to reflect the actual cost, that is not the situation today.

Chairman STARK. Dr. Anderson, the administration testified that your worries are groundless, that every plan is going to have to contract with your academic health centers and therefore they can't exclude the chronically ill population going there. How do you respond to that?

Mr. ANDERSON. I think there is a number of concerns here. What they are basically saying is there will be a list of services that the academic medical centers should participate in. And they haven't provided that list.

I am not sure that there is a list that in fact exists. We don't know—the department has been changing its definition of an academic medical center, sometimes it is 1,200 hospitals, sometimes it is 120 hospitals, so that is changing.

It is unclear whether health plans will be forced to contract with all academic medical centers, only some academic medical centers, or which academic medical centers would be involved. How will they contract with academic medical centers is unclear.

Would they get paid the average rate when they are taking care of the chronically ill, the very sick person, or are they going to just take care of patients at a normal rate?

We don't know what the level of cost sharing exists in the point-of-service arguments. We don't know how much the point of service option is going to cost, so there is no guarantee that the academic medical centers will get any business at all or the psychiatric hospitals or any other specialty provider under this type of scenario.

It is a nice set of about six lines in the legislation, but there is a lot of information that needs to be provided before you know whether or not there will be any market for any of these specialty providers.

Chairman STARK. Yes, I can see a case where, if you provide, again, let's just take our own neighborhood, people in Anacostia, a center of excellence at Duke University, you might as well put it on the Moon, huh?

Mr. ANDERSON. Absolutely, and you can make a justification for that that, you know, we mentioned earlier.

Chairman STARK. Amtrak goes there.

Mr. ANDERSON. Duke is just absolutely wonderful in doing cardiac surgery, and so you should send all your patients to Duke for that, and you should send all your patients that are going to get transplants to Presbyterian in Pittsburgh and maybe send some out to UCSF to—

Chairman STARK. Do you know that Delta Airlines does that by the way? They include a pass, not only for their employee, but for two family members or friends for major—I think the brochure I saw, cardiac stuff, if you go from wherever you are to centers. Some weren't so shabby, Cleveland Clinic. Go to the Cleveland Clinic, they got a deal. I don't care whether you live in Memphis or San Diego. You get the airline transportation and pack up the kids and off—they pay your hotels while you are there, I guess we considered that in Medicare once or twice for a variety—I mean with a differential between where a procedure is so low say in Atlanta between San Francisco. What the heck, you can throw in a first class round-trip airfare and still save money.

I am not sure we would be able to sell that politically.

Mr. ANDERSON. Nor would a hospital keep 800 or 900 beds filled with just those types of people flying all over the country to do that. It would also have a devastating impact on the educational system because all the residents would see a very narrow set of patients and that is where most of all our training occurs.

Chairman STARK. Ms. Rosenblatt, you indicate in your statement that reinsurance has to be developed carefully or you will start to reward the inefficient and encourage health plans to provide excessive treatment services.

And since the administration relies on reinsurance as a short-term approach, can you tell us a little bit more about your concerns in that—

Ms. ROSENBLATT. Yes, I would be glad to. There are several ways to design a reinsurance system. The simplest way to do it would be to require a per capita type of payment for each individual insured in the total system, and then when a claim occurred, to actually reimburse the carrier for the full amount of that claim.

So if that carrier or health plan provided a lot of unnecessary services, they would be rewarded because they would be paid for all of their services. That is the type of system we think it is very important to avoid.

The system that we think is a very good system and that we think can be expanded upon, is the system used in the State of New York where specific conditions are identified. Those conditions cannot be upcoded, I use that word, meaning that the conditions are things like transplants, and it is unlikely that a physician is going to have a patient go through a transplant if it is not absolutely necessary just so that the plan gets reimbursed for that.

Chairman STARK. You know, I saw some amazing examples. Are you familiar with psychiatric treatment at Kaiser, Mr. Luft?

Mr. LUFT. A little bit.

Chairman STARK. The one visit psychiatric treatment, is that a new one to you in your—

Mr. LUFT. One visit would be—

Chairman STARK. One visit for pills, that is it.

Mr. ANDERSON. My wife is a psychiatrist in the local Kaiser and she does—it must be different.

Chairman STARK. They are developing rooms, they are building a new center in my district, and I have noticed they had all these—this is for psychologists—all these counseling rooms, and it is a training center in addition, but I did hear that they are developing a one-visit diagnosis treatment—and you could save some money in that, I think, now that I think about it.

Mr. LUFT. What I would want to make sure is that if anybody were doing that, that we would very carefully assess outcomes. I think that we need—

Chairman STARK. Mr. Luft, assessing psychiatric outcomes is something that transcends even risk adjustment. Good luck.

Dr. Anderson, have you got any studies—Dr. McDermott wanted me to ask this—on the relative costs to the government of developing a target premium to enforce cost containment as compared to the costs of developing a national fee schedule?

Mr. ANDERSON. We are in the process of working on that, but we do not have it completed yet.

Chairman STARK. What is your guess? Is it going to be more expensive to develop a target premium?

Mr. ANDERSON. I think we basically have a fee schedule established for the Medicare program. We have it both for hospital and physician services. I worked with Paul Ginsburg and Phil Lee

awhile ago in evaluating the possibility of expanding it to that for physical services. As they reported to you, in fact, it seems relatively inexpensive to do that.

Chairman STARK. To develop what?

Mr. ANDERSON. To develop a payment system for all payers which—

Chairman STARK. Which would be a fee schedule?

Mr. ANDERSON. Which would be a fee schedule, correct.

Chairman STARK. Would you say that that is less expensive than a system to monitor premiums?

Mr. ANDERSON. I would expect it would be, yes, but we haven't finished it, but I would expect it—

Chairman STARK. So you say it would be less expensive to develop a fee schedule and over time it would be less expensive to maintain it as opposed to doing the premium cap and monitoring?

Mr. ANDERSON. We don't have the outyear projections from the Congressional Budget Office yet, but I would expect that they will show that, but we don't have that yet.

Chairman STARK. OK. Now, my plan that I suggested in my first question that maybe just everybody gets together and negotiates how we divvy up the pie within an alliance was a terribly unsophisticated and pedestrian paraphrase of your testimony, Dr. Luft.

I think you suggest that rather than worry about the precise mathematical formula, kind of the Magaziner approach, we just rely on a process yet to be defined where health plans sort of check up on each other and negotiate sharing risk within an alliance.

Is that a little closer to what you testified?

Mr. LUFT. I wouldn't call it negotiation, but—

Chairman STARK. Take the side bars out of there.

Mr. LUFT. Basically it would be identifying the—along the testimony Alice gave on specific diagnoses, the New York model, for example. One can start with a list of 15 or so. The problem is that list might be different in different areas. Certainly in the Bay area, HIV is very important. It is probably not terribly important in Fargo, but there may be some other diseases in Fargo, North Dakota that are more important than HIV, and so what I was suggesting is that the health plans would put on the table how they thought they were having adverse selection, and then the health alliance would have to play the role of a referee, not to let somebody come in without some documentation.

Chairman STARK. Put all of the wolves in one room with a fixed dollar amount, then they got to come out of the room splitting up the zero sum, is that—

Mr. LUFT. I think it is better than trying to do it from Baltimore.

Chairman STARK. But Dr. Anderson would say we wouldn't have to worry about that if we had a fee schedule.

Mr. LUFT. I think there are certain parts of the country where going to a single payer system with a fee schedule is probably just fine. Although, if those places have some HMOs, we need to figure out how to pay them. It is the Medicare problem.

Chairman STARK. Mr. Lubitz is going to do that for us.

Mr. LUFT. Right, and I trust Jim. There are other places in the country where I think a fee schedule doesn't deal with the problem of too many providers or too much volume, and that is the only

reason why some parts of the country, our part in California, I prefer a managed competition model because I don't know how anybody is going to decide which of the 120 hospitals in the State that are doing open heart surgery are going to not do it in the future. However, competing health plans can decide which hospitals they are not going to select to contract with.

Chairman STARK. Well, we could decide that. First of all, you would throw Humana out where they do one every 6 months.

Mr. LUFT. Yes, OK.

Chairman STARK. And it just is a loss leader. It seems to me that in the Bay area, we have been certifying these heart centers where they literally do one or two a month, and that is hardly enough for people to remember where the heart is, much less how to transplant it.

Mr. LUFT. And there is good evidence that I have worked on that shows that their outcome is remarkably worse. The problem is that our excess supply of physicians is exceeded only by the excess supply of attorneys, and I am worried about the regulatory process.

Chairman STARK. With term limits, you are going to have a lot of former politicians in there too. That will really complicate your studies.

We have a competitive system that is I think as good as it is going to get in the Bay area. Arguably 70 percent of the people in the Bay area belong to some kind—and I don't mean just these—they have got some awful operators in southern California. They call it managed care, but it is a bunch of fee-for-service guys who have got a gate keeper that is ferocious.

Mr. LUFT. Usually in Omaha.

Chairman STARK. And they really are unconscionable operations, but take those out. We have got some good plans in northern California and they have—I mean, Kaiser, as much as I love them, has made risk selection an art. They really have a low-risk population that they have developed over 50 years relative to the rest of Alameda County.

Half the people in Alameda County belong to Kaiser, half, and they provide service with a quarter of the number of hospital rooms and a third of the number of docs as the rest of the county. That is not bad service.

You get an argument any place in town and they didn't get that by taking all the sick people in town. You know that, and the question is, why can't you, in a community like that, what happens if you allow Medicare to come in and compete at the government's actuarial cost? Why does that destroy California's purse or anybody else if we just say, all right, we are all at the same benefit level for a minute because I don't think we can afford the President's benefit level. Why does that destroy our system?

Mr. LUFT. I personally don't have a problem with Medicare coming in.

Chairman STARK. The fail-safe, I mean.

Mr. LUFT. Right. I think the important parts are universality of coverage so that you can't dump people and have them not end up in some plan. If you had Medicare as a fee-for-service provider with comparable benefit packages for everybody else, I don't see any

problem, and you could argue that Medicare will very quickly then wipe out the other fee-for-service carriers.

Chairman STARK. Not if we stay at Medicare rates necessarily. I mean, I can think of cases, perhaps some of the western plain States, where they could come in under us. They can't in Los Angeles, they can't in Manhattan, probably can't in Boston.

We are 75 percent of probably what you collect in Boston and 60 percent of what you collect in Los Angeles, but we might pay more.

Mr. LUFT. But part of that depends, I think, on whether Medicare is allowed to behave as aggressively as other health plans in a local area or whether they are stuck with a formula. But I don't have a problem with that.

Chairman STARK. OK, I asked Dr. McDermott's best question, but you got your second best question for the panel.

Mr. MCDERMOTT. Thank you, Mr. Chairman. My question is to you, Dr. Anderson. As I think about this risk adjuster question and whether we have adequate ones or not, I keep asking myself if we don't develop them very quickly, what do you think the likelihood is that there will be a children's hospital left in the country by the year 2000?

Mr. ANDERSON. I don't know if there won't be a children's hospital, but it will be a very weakened children's hospital system and there will probably be not a lot of academic medical centers, a lot of psych hospitals.

They are all going to suffer dramatically from risk selection. They are starting to understand the importance of this because this really affects what they clearly do most, which is fee-for-service activities, and inadequate risk adjusters are going to keep the fee-for-service activities away from them. That is exactly what they are concerned about. They are starting to wade through the 1,300 pages and understand that issue.

Mr. MCDERMOTT. Early on, I talked with the White House about the funding of medical schools and pointed out that in the State of Washington, from my experience there in the State legislature, 15 percent of the funding for the university medical school comes from the State legislature, 50 percent is Federal grants, and 35 percent is from fee-for-service medicine practice. I suspect it is similar across the country, although I don't know the figures, maybe you do.

Mr. ANDERSON. The only difference would be that many of the places like Johns Hopkins don't get that 15 percent from the State.

Mr. MCDERMOTT. In their plan, they try to deal with this by requiring people to make connections to these academic health care centers. Can you explain to me how they think that would work? Is it clear to you how they think that would serve to bolster the academic medical centers?

Mr. ANDERSON. I understand the intention. The intention is to have each of the health plans contract with an academic medical center, and therefore, you reduce the amount of risk selection.

Now, the problem is that we don't know what they have to contract for. We don't know how they have to contract in terms of a price. We just don't know anything about the mechanism, so it is a nice four lines which was put in there, but it is right now completely window dressing. There is no way for—no protection for any

of these specialty providers, either they being practitioners or children's hospitals or any type of specialty institutional provider in there.

That is just not an important part that you can rely on.

Mr. McDERMOTT. As I read it, it appeared to me that if you require an HMO or any plan to contract with the University of Washington for specialists, but then you have to set up a situation where you try to exclude people from seeing specialists, it may be really a hollow connection if you find some way to deal with your problems without getting them up to the university hospital.

Is that how you see it?

Mr. ANDERSON. It is. One of your friends, Bill Richardson, I spoke with him on Saturday, and he is the President of the Johns Hopkins University, and we went over this provision.

Hopkins is doing strategic planning, and he just saw this as not being a help to him at all. He likes it in there, but he doesn't see it as having any real teeth. Maybe it could be made with a lot of teeth, but it doesn't have it now.

The children's hospitals are concerned about this. I was down at Duke last week. They are concerned about this issue. It is starting to raise to the top of their agenda.

Mr. McDERMOTT. It seems to me that the real problem of risk adjustment, as you said earlier in your testimony, is the whole question of how you deal with chronicity. That seems to me the weakest part of managed care as an encompassing system. They don't deal well, or many of them have had difficulties in dealing, with the chronic problems, whether they are medical or emotional. Without risk adjusters, then I don't see how you are going to do that.

Because one of the problems, it seems to me, that always is frustrating is that you can't tell somebody coming in the door whether this is somebody who is going to cost you a whole bunch or nothing, very small amount, and sort of reinsurance business that once they hit a certain point, you plop them out of it. I really don't understand how they think that works.

Do you understand how the reinsurance is handled? What kind of a trigger would you use, a simple dollar trigger?

Mr. ANDERSON. What you see in New York State, for example, is the dollar trigger. If somebody who had—needs a bone marrow transplant or something like that, there is a \$120,000 payment associated with that individual. It represents a very small percentage of the business that a children's hospital or an academic medical center provides.

I mean, it is certainly something that is important, but to make it work, I think you need to do a list of several thousand of these chronic illnesses because you need to do one with children with cystic fibrosis, and not all children with cystic fibrosis are exactly the same, or not all mental illnesses are the same, or not all types of AIDS are the same.

So once you start getting into these more sophisticated reinsurance systems, you are effectively developing a risk adjuster and that is, as I said in my testimony, 5 years, at best, away.

Mr. McDERMOTT. What is a reasonable interim solution? Let's suppose that we want to do what the President is suggesting. What

is a reasonable way for us to proceed until we have 5 years' experience——

Mr. ANDERSON. Well——

Mr. McDERMOTT [continuing]. Without bankrupting the system and having an open purse essentially?

Mr. ANDERSON. I guess you can hope that Harold Luft is correct, that if you lock people in the room, they will come up with a reasonable solution. I guess I am less confident that that in fact will work. I think that an academic medical center or children's hospital will come in there and say, I have got all these sick patients and the other members of that organization will say, sorry, we just don't want to play with you, we think that you are unnecessarily high cost; we think that it is your problem, not our problem, and they won't leave the room amicably, but they might, so that would be a potential short-term solution.

I think we have got to start working on research on this stuff. We don't have any research funded by the Federal Government right now looking at the non-Medicare population, and until we start this research, we don't know how long it will take to complete this research.

Mr. McDERMOTT. Dr. Luft, you are listening. Maybe you have some comment on it. Let me give you my perspective on this issue. I question the idea of reasonable people in a room, I, during the legislature in 1984, started putting together a risk pool to share the uncompensated care in the State of Washington, and trying to place some people in the pot and to let other people to be able to be taken out of the pot because they had more of one or the other. I never got it through.

I failed miserably. So I would like to hear how you think that can be done. How do we bridge the 5 years to the year 2000?

Mr. LUFT. Excuse me. Did you fail in the legislature or in your actually doing it?

Mr. McDERMOTT. I can do it on paper. I can do it academically—this is how it would work with everybody, but I couldn't get the votes for it because I couldn't get the hospitals to agree, and they ran a campaign against me called Vote Against the Sickness Tax in the newspaper—so I had had lots of experience with communities and their willingness to share risk with somebody else. We will pay for your risk.

Mr. LUFT. Right, and I think in a sense, I was talking in the context of suppose the administration's proposal got passed, which I think was how you prefaced your question. If everybody is in a health alliance, then some of the health plans that are in that area will have favorable selection, but all will claim adverse selection.

If I am the regional manager of the health alliance, I would say, well, in what categories do you have adverse selection? Put the evidence on the table here. You have got lots of cystic fibrosis—20 percent of the cases and 10 percent of the population. Somebody else has HIV patients. Somebody else has people with longstanding congestive heart failure. They will bring it to the table.

They wouldn't have the option of walking away as they did in your legislative setting saying, sorry, I don't want this legislation. Now, they have that option.



That is the process that we are going through right now, which is changing the legislation which now allow some people to avoid the risk.

Mr. McDERMOTT. So what you are really suggesting is that another role of the alliance—because I keep trying to figure out what all is going to happen with the alliance, I hear the subsidies and the premium setting and so forth, but another rule is going to be saying to everybody, look, folks, we don't know how to do this fairly, so for the next 5 years we are requiring everybody to throw in 1 percent of revenue into a pot, and then we will decide what is a reasonable way to redistribute that on the basis of the risk.

Mr. LUFT. And my sense is I think they can start doing it relatively early on. The New York model is a beginning. In other words, they put that on the table and say, do you have other categories that you want to add? The adjustment doesn't have to be perfect; it has to be good enough for the health plans to feel that they have a reasonable share.

Now, I don't know the situation at Hopkins very well. I know University of California, San Francisco or Los Angeles have literally hundreds of contracts with different managed care providers. They are working on ways of how to deal with the risk adjustment.

Another piece of it is, if a health plan gets pushed out into a death spiral, and drops out of business, their patients have to get picked up by the surviving plans. If everybody refuses to cover or refuses to pony up for the disproportionate number of HIV cases that one health plan might have in San Francisco, it doesn't mean that those HIV cases will go away. It means that everybody else will have to get them early on.

I think the——

Mr. McDERMOTT. It seems to me, the alliance has the ability to redistribute and say, this patient will come to you and this patient will come to you and——

Mr. LUFT. Or I think the alliance may need some powers, certainly be an assertive referee, in essence say——

Mr. McDERMOTT. And a penalty box.

Mr. LUFT. Possibly. Because I think the notion is to set up the rules of the game that are going to be fair so that the health plans get down to the business of competing on the basis of efficiency, not dumping patients.

The other piece of it, I think, and here I clearly differ with the administration—is that I think each regional health alliance needs to have some latitude in figuring out how to implement the processs. I think a single national set of weights and categories probably won't work.

It will be too easy for plans in different localities to figure out ways to "beat the system." For example, the problems in a regional health alliance that has a big medical school versus one that doesn't will be very different, in terms of where people are used to normally getting their specialty care.

So the weights, the things you need to think about are very different. Thus, I would give a fair amount of discretion to those health alliances serving as referees, maybe with oversight by the National Health Board.

Mr. McDERMOTT. My understanding is that the President puts that decision making at the State level, so I think there would be the possibility of the States getting different levels of responsibility. Is that not how you view it? Do you think it should all be decided by the National Board?

Mr. LUFT. It is not clear to me. I just read over the text this morning and it could be, I think, interpreted either way. I think it is a question of implementation.

Mr. ANDERSON. My concern is when you lock these people in the room at the academic medical center, the children's hospitals, basically goes out of business and we lose the infrastructure that we have built up over time. I think that is a real possibility.

Those are the institutions that are going to attract the sick people. Those are the institutions that are most vulnerable, and those are the ones that everybody else can agree that they have got all the sick patients, they are very expensive, and so they are not going to necessarily play with them in this negotiation.

Mr. McDERMOTT. You are suggesting a sort of recreation of the town and gown battle that has gone on in most academic settings over the last 40 years where you are really saying the local hospitals would like to absorb the patients that are locally taken care of by both the academic health center and the children's hospital.

Mr. ANDERSON. What they would really like to have is the academic medical center take them all and lose all sorts of money taking care of them for a while. That would be the best of all worlds.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

At a certain size, a pool is large enough to manage the risk within it. At what size would you say risk adjustment is not an issue?

Mr. ANDERSON. When you have got everybody in the pool. When you have got everybody in the State in the pool, like a single payer system. Until you have got a single payer system, you are going to get serious risk selection.

Mr. LUFT. I think size eliminates random risk. It doesn't eliminate purposeful risk selection. You can have 10 million people and if you have got somebody at the door who can identify the high-risk cases, the 10,000 out of the 10 million, they will do it and you have got major risk selection.

Mrs. JOHNSON. But most large group plans, whether they are self-insured or not, are required to take everyone in the plan. Now, of course they select risk by being in whatever line of business that they are in, but it appears to me that so much of the market works well using only reinsurance as a risk back-up, that it is unwise to assume that you have to put everybody into a single group in order to deal with this problem.

Mr. LUFT. The University of California with 120,000 enrollees is a large employer. We have substantial bias selection among the people who have chosen the various health plans that the university offers.

If we only had a single plan, then there would be no risk selection within the university, but we offer a number of different HMOs.

Mrs. JOHNSON. But to what extent do the higher costs from plan to plan offset that?

Mr. LUFT. You mean the higher claims?

Mrs. JOHNSON. Insuring a higher risk group is more expensive, and if people choose a more expensive plan, they pay more for that plan, and so there is some relationship between costs and risk in a situation like CALPERS.

Mr. LUFT. Right.

Mr. ANDERSON. So what you do is you get all the sick people, all the chronically ill people in the highest cost plan so you effectively push all the sick people into the—

Mrs. JOHNSON. If they know they are going to be sick, and so you have got one group that knows they are going to be sick and they are high cost, but the normal cost variation is unpredictable, and—according to earlier testimony.

Mr. LUFT. Right, but, for example, in the university and in CALPERS, the fee-for-service plans have a disproportionately large number of older people. Older people will very predictably, on average, have higher expenditures than younger people, and without some risk adjustment, in essence, what we are having there is older people paying a higher premium than younger.

Mrs. JOHNSON. And the higher premium covers their costs, otherwise they would be out of business, right?

Mr. LUFT. That is right, but that is having the older person pay more because they are higher risk, not necessarily because they have chosen a less efficient plan.

Mrs. JOHNSON. I understand that, but you see, the social issue, the policy issue here is, if we go to community rating, we raise everybody's costs and the younger people pay the higher cost people's risk.

Now, it is one more way in which younger generation people are going to subsidize the older generation. They subsidize them now in terms of income. They subsidize them now in terms of Medicare. Now, they will subsidize a group from 50 to 65 in terms of health risk. If they can afford the higher cost insurance, why shouldn't they pay it? Many of them make more money than the younger guys.

So I think that you have got to be careful when you are talking about risk adjustment that we are clear about what is that piece of the problem that you have to solve to have health care available to everyone and even be able to just make it affordable even through subsidies versus the social policy implications of leveling, and the administration's plan does go immediately to community rating.

Now, what is the consequence—how can we go immediately to community rating without a good risk adjustment mechanism, and what are the consequences of that? We have had testimony before this committee that community rating will increase the premiums of 80 percent of the people out there, and when you look at the generational content of that reality, you have to say, does health care reform have to be done that way.

So I am interested in your comments about the spin-off on community rating, if it is useful, but it does seem to me that size of group matters to how much risk adjustment is necessary. In other

words, you could do it without doing the President's plan. You have a uniform plan, a single plan. You require a guarantee issue, guarantee renewability, and the same price is charged for that plan inside or outside of the HPPC or across that market.

Then you deal with a lot of the risk selection issues, and therefore, until we see what the consequences are, because in California, it does appear that there may not be risk selection, you certainly want to jump into risk selection, particularly risk selection that immediately leaps into intergenerational subsidy without regard to ability to pay.

So my question is, to what extent can we deal with the risk selection issue by restructuring the non-functional part of the market, which is the market for individuals, the market for small groups, no matter how you define that, say up to 100 for convenience, 100 employees, to what extent can we deal with our problems by simply requiring that in that market there be a very clearly defined benefit plan that is uniform, that we require everybody to offer it at the same price?

I mean, companies don't have to offer it at the same price as other companies, but they have to offer it at the same price to everyone and they have to renew it. To what extent does that deal with the risk issue?

Mr. LUFT. There are two pieces to the problem. I think that would deal with a substantial fraction of the risk issue if we were only looking at identical fee-for-service plans. If the only thing that changes is the color of the card that I hand to my independent solo practitioner—

Mrs. JOHNSON. And possibly the price reflecting quality or something.

Mr. LUFT. But if I have free choice of all providers, then the quality is the same. The only thing that really differs is how fast they do their paperwork or efficiency in reimbursing my claim.

Mrs. JOHNSON. Who is in the system, what doctors are in?

Mr. LUFT. Once we start talking about different physicians in the system, then the provider network can be manipulated to encourage high-risk people not to be in, because, for example, we have oncologists but none of them—

Mrs. JOHNSON. To be an accountable health plan, you have to demonstrate that you can serve the geographic area that you are a part of?

Mr. LUFT. Oh, absolutely. I cover the geographic area; I have board-certified oncologists, but none of them speak English very well.

Mr. ANDERSON. I have one board-certified oncologist to take care of 200,000 people.

Mrs. JOHNSON. Let me ask you this, because I hear exactly what you are saying. You could risk select through ever more complicated sophisticated mechanisms. If you are in the market to offer your plan, what evidence is there that, for instance, in California where now this is quite a developed market, and where business is growing and every month 20 percent of the new people coming into the system have not had insurance before.

What evidence is there that, in fact, at the micro-level like this there is this risk selection going on because the Board that over-see it doesn't see that?

Ms. ROSENBLATT. We have a lot of evidence in certain States where certain carriers can't do medical underwriting. Other carriers can do medical underwriting. It exists in Massachusetts.

Mrs. JOHNSON. I think that is a very important point. You have to have uniformity, and the interesting thing about California is they have uniformity, both within the HPPC and outside the HPPC, so there is an obligation outside the HPPC to charge the same price for the same plan as inside.

So I hear what you are saying in terms of uniformity of benefit and certain price uniformity, and the same rules, because we are just now developing markets with this kind of consistency, it looks to me like that consistency alone will deal with a significant part of this problem which we are not prepared to deal with technically.

Ms. ROSENBLATT. I think the consistency you are talking about will deal with it, but you need to look at all aspects of it, and I think one of the things that we actuaries are particularly concerned about is community rating, which you have mentioned.

If there is pure community rating as part of that system, then risk adjustment is absolutely necessary. If community rating by class were permitted, for example, if the rating structure were allowed to recognize demographic variables, then there would be less of that intergenerational subsidy issue that you are talking about, and the risk adjustment mechanism would not have to account for age differentials, but it would still have to account for some of the other variables that—

Mrs. JOHNSON. What if you allow age, sex, and geography?

Ms. ROSENBLATT. If you allow age, sex, and geography, I think you clear up the intergenerational problems, although that mainly is, today, a small group issue and an individual purchaser issue.

Keep in mind that most large employer groups today use a single rate for all employees, young and old, for a given plan.

Mrs. JOHNSON. Yes, and in the market that is the problem.

Ms. ROSENBLATT. The other aspect of introducing the Medicare population into the alliance and then having one rate that includes the Medicare population worsens that intergenerational problem.

Mrs. JOHNSON. Even if there is an age differential?

Ms. ROSENBLATT. No. If you have the age differential—

Mrs. JOHNSON. Because if there is an age differential, then you could compensate according to income—those seniors who couldn't afford the rates. So anyway, we need to go vote and I will read your testimony. I am sorry I couldn't be here for it because I am very interested in this subject and interested in how we structure a more voluntary market than the President's market, and yet avoid some of the problems that we have had in the past.

Thank you.

Mr. McDERMOTT. [Presiding.] I think this is probably not the last time that we will see you folks, and we appreciate your contribution today. It has been very helpful. We will recess and the chairman will return for the final panel in about 10 minutes.

[Recess.]

Chairman STARK. We will go back on the record. As far as I know, the members have exhausted their questions on the previous panel. We have our new panel.

Our final panel whose expertise is only overshadowed by their patience is made up of Cecil Bykerk, senior executive vice president and chief actuary of Mutual of Omaha Companies appearing on behalf of the Health Insurance Association of America, and Henry Bacher, executive director of the Center of Health Economics and Policy Research for the Blue Cross and Blue Shield Association.

Gentlemen, welcome.

Mr. Bykerk.

**STATEMENT OF CECIL BYKERK, SENIOR EXECUTIVE VICE PRESIDENT AND CHIEF ACTUARY, MUTUAL OF OMAHA COMPANIES**

Mr. BYKERK. Mr. Chairman, I am here representing the Health Insurance Association of America and its views on risk adjustment in health plans under the President's reform proposal.

Chairman STARK. I am going to ask both of you to get the microphones up real close. It is tough for our guests and me to hear.

Mr. BYKERK. The HIAA supports a number of provisions in the administration's bill. We want to be a responsible participant in the national health care debate. We are eager to work with the administration and Congress in developing national reform which achieves universal coverage, promotes individual responsibility and cost containment, preserves choice and maintains the quality of our health care system, much of which can be accomplished through reform of the small group and individual insurance markets.

In particular, we agree with much of what has been proposed by risk adjusters. You have heard a lot about risk adjusters.

I would like to focus on a few key points we think are especially important. First, in reforming the health care system, Congress needs to include some method of risk adjustment.

In other words, there needs to be a way of matching premium revenues by health plans with the underlying risk of the population they are enrolling. This is because almost all reform proposals, including HIAA Vision for Reform, call for open enrollment and rating restrictions to at least some degree.

An effective risk adjuster would ensure the revenue received by a plan is consistent with the underlying risk of its enrolled population. This is a necessary factor for the solvency of any plan and ultimately the viability of the entire system.

The HIAA does not believe the risk adjuster should eliminate all differences in premium or health risks from the system. Insureds should still have incentives for pursuing healthy life styles and health plans should retain the responsibility for managing the remaining risk in the system.

Risk adjustment mechanisms should apply across-the-board to all health plans.

Chairman STARK. What about that incentive thing again, Mr. Bykerk? Is there anything any of your members have incentives for except smoking?

Mr. BYKERK. That is the most specific one.

Chairman STARK. Celibacy? Abstinence?

Mr. BYKERK. No. Other wellness——

Chairman STARK. Prayer? Religious biases?

Mr. BYKERK. No.

Chairman STARK. So it's smoking?

Mr. BYKERK. At this point smoking.

Chairman STARK. OK.

Mr. BYKERK. Risk adjustment mechanisms should apply across-the-board to all health plans, employers and individuals within the market. That is, there should be a level playing field and the mechanism should be unbiased.

The second point I would like to make is that actuaries are confident risk adjustment mechanisms are sufficient to justify selection within a group setting.

On the other hand, when employees rather than employer groups get to choose which plan the employee will join, the magnitude and accuracy of the risk adjusters have to be much greater than when the employer chooses a health plan that all its employees join.

For example, the HIAA believes that risk adjustment is similar enough to currently existing rating and reinsurance approaches to make us reasonably certain that blocks of employer-sponsored plans could be risk adjusted to the extent necessary to preclude risk selection by health plans. This result can be achieved because within almost any employer group, healthy lives would be combined with unhealthy lives which reduces the distribution of average costs per insured between different employer groups and therefore between health plans, as well.

This is illustrated in charts 4 and 5 in the written testimony. I personally expect that a risk adjuster can be developed that will accommodate the adverse selection that will occur with individual selection; but as of today, there is no research or evidence to assure us that risk adjusters currently being proposed would be accurate enough. HIAA is currently conducting a study based on member company data that will evaluate the efficacy of different types of risk adjusters. We hope to have this demonstration project completed and report available early next year.

If health care reform is implemented before adequate research can be completed, an interim risk adjuster should be implemented based on information readily available to health plans, including a mandatory, broad-based reinsurance pool for spreading the costs of a limited number of high cost, non-discretionary conditions among all plans.

Finally, I would like to note that an effective risk adjuster would eliminate incentives for plans to avoid enrolling high risk individuals. By risk adjusting the average claim costs that the plan pays, the sum of the expected claim cost and the risk adjustment transfer payment would be approximately the same for all the individuals.

Chairman STARK. Say that again.

Mr. BYKERK. By risk adjusting the average claim cost that the plan pays, the sum of the expected claim costs and the risk or the risk adjustment transfer payment would be approximately the same for all individuals: high risk or low risk. The risk adjustment pooling mechanism would work the same way no matter which plan the individual joins and regardless of whether a plan is inside

or outside of a purchasing pool. Thus mandatory purchasing alliances are not necessary for health risk adjustment to work.

In conclusion, the risk adjuster will allow plans to compete on their ability to manage the costs of providing needed care rather than on their ability to select the healthiest lives. The HIAA welcomes the opportunity to work with the administration and Congress to develop a risk adjuster that works for all Americans.

[The prepared statement and attachments follow:]



**TESTIMONY OF CECIL BYKERK  
SENIOR EXECUTIVE VICE PRESIDENT AND CHIEF ACTUARY  
MUTUAL OF OMAHA COMPANIES**

Mr. Chairman and members of the subcommittee, I am Cecil Bykerk, Senior Executive Vice President and Chief Actuary, Mutual of Omaha Companies. I am also a Vice President of the Board of Governors of the Society of Actuaries and a member of the American Academy of Actuaries. I am here today representing the Health Insurance Association of America (HIAA) in response to your request for comments on issues relating to risk selection and risk adjustment by health plans. HIAA is a trade association of about 270 commercial insurers covering approximately 65 million Americans.

The focus of my testimony today is on health risk adjusters: what they are, why they are needed, what the current state of the art is, and how well they work with or without health insurance purchasing cooperatives.

**Risk Adjustment and Risk Adjusters Defined**

According to the American Academy of Actuaries, a risk adjustment mechanism is a two-step process of risk assessment (determining the relative health risk of individuals compared to an average) and risk adjustment (transferring money among carriers based on the composite risk assessment of all individuals each carrier insures).

The term, risk adjuster, is used by some researchers and actuaries to refer to the risk classification method used to assign relative risk values to individuals, but the American Academy of Actuaries considers this to be part of the risk assessment step of a risk adjustment mechanism.

The term risk adjuster is also used generically to refer to the entire risk adjustment mechanism (risk assessment and risk adjustment). Risk adjuster is used in this context throughout this testimony, and will be used interchangeably with the term, risk adjustment mechanism.

**Need for Risk Adjustment**

Congress, in reforming the health care system of today, will need to include some method of risk adjustment, i.e., some way of matching premium revenues received by health insurers with the underlying risk of the population they are enrolling. The American Academy of Actuaries has said that "under most reform proposals, some form of health risk adjustment will be required to allow reform strategies to work effectively." We agree. This is because all reform proposals, including HIAA's own Vision for Reform, call for open enrollment and rating restrictions to some degree or another. Such proposals dissolve the link between the premium the carrier is allowed to charge and the costs the carrier expects to incur in serving a particular individual or group.

In the current market insurers adjust premiums up front to reflect the relative risk of insureds (see Chart 1). Individual insureds are placed in broad pools with other individuals with similar risk characteristics, called risk classes. All of the individuals in a particular risk class are then charged the same premium based upon the average claims cost of all individuals in the class. Individuals in certain risk classes may be called low risk--such as a risk class of young nonsmokers--because the average claims cost of individuals in this class is less than the average across all risk classes. Individuals in other risk classes may be called high risk--such as older smokers--because their average claims cost is higher than the average across all risk classes.

Thus, a low risk person might have claims cost and premiums that are half of the average claims cost and premiums across all risk classes. A high risk person might have claims cost and premiums that are three times the average--as illustrated in Chart 1.

If health plans are required to charge the same premium to everyone they cover, each insured person would pay a premium

equal to the insurer's average premium across all risk classes, say \$300 a month for a single person (see Chart 2). This average for all insureds is much closer to the average for low risk insureds because there are more low risk insureds than high risk insureds. However, just equalizing everyone's premium would do nothing to the underlying claims cost. A low risk person would still cost the insurer (or, have expected claims cost of) about half of the average while a high risk person would have expected claims cost of three times the average. This situation would still leave a great incentive for carriers to avoid high risk persons.

Chart 3 shows how health risk adjusters help to solve this problem. By risk-adjusting the average claims cost that the insurer pays, the sum of the expected claims cost and the risk adjustment transfer payment will be approximately the same for individuals in each risk class. Hence, the insurer would theoretically become indifferent to selling coverage to a low risk or a high risk person. The insurer's premiums would once again be back in line with the underlying risk of the population it is enrolling--an important factor for the solvency of any insurer.

### The State of the Art

The goals of risk adjustment in health care reform proposals can be reduced to two basic objectives: (1) elimination or reduction of risk selection by carriers and (2) elimination or reduction of the financial impact of carriers receiving a disproportionate share of high-risk insureds.

The first objective is to make sure that carriers compete on the basis of administrative and medical efficiency and not on the basis of how well they can select healthy lives. HIAA firmly supports this objective.

The second objective is to protect carriers and their policyholders against the threat of insolvency when open enrollment and rating restrictions combine to prevent the carrier from charging a premium that reflects the actuarial cost of the insureds it covers.

In addition, the magnitude of risk adjustment required is directly related to the magnitude of rating restrictions in the system. For example, the magnitude and accuracy of risk adjustments would have to be greater in a community-rated system than in an age-rated (community rated by class) system.

From the perspective of some policymakers, the goal of risk adjustment is to reduce premium differentials. From our perspective, this can be taken too far, i.e., the risk adjustment mechanism should not strive to eliminate all differences in premium or health risk from the system. If all health risk were removed from the system by risk adjusters, there would be no incentive for carriers and insureds to manage or reduce risks--such as to obtain preventive care or pursue healthy lifestyles. Insureds should still have incentives for pursuing healthy lifestyle choices, and carriers should retain the responsibility for managing the remaining risk in the system.

Policymakers have also suggested that a risk adjustment mechanism could be designed that would facilitate subsidizing low-income and needy individuals. While we believe these subsidies are a necessary part of reform, they should not be a part of the risk adjustment mechanism. Such a policy would cloud understanding of the highly technical risk adjustment mechanism and potentially undermine its primary objectives. In short, risk adjustment mechanisms should not try to further other social policy goals unrelated to health risk adjustment.

Risk adjustment mechanisms should apply across-the-board to all health plans, employers, and individuals within the applicable market (e.g., specific geographic area and designated employer

size), regardless of the mechanism through which the coverage is obtained. That is, there should be a level playing field and the mechanism should be unbiased.

With the discussion of health insurance purchasing pools, another question arises that is affected by the current state of the art for risk adjusters. When employees, rather than employer groups, get to choose which plan the employee will join, the magnitude and accuracy of the risk adjusters have to be much greater than when the employer chooses a health plan that all of its employees join.

Chart 4 shows the claims experience of individuals within a typical employer group. The annual claims cost per individual ranges from about \$57,000 to \$0 with about 20 percent of the individuals incurring 80 percent of the cost.

Chart 5 shows a comparable distribution of the average claims experience for a number of employer groups, ranging from about \$1700 to about \$2900 annually.

These two charts illustrate that the variance in cost is much greater for individuals than for employer groups. It is much easier for a risk adjuster to compensate for the variance in costs between employer groups of insureds when the highest average rate is less than two times the lowest average rate than it is for a risk adjuster to compensate for the variance in costs between individuals when the highest rate is over \$50,000 and the lowest rate is \$0.

We believe that risk adjustment is well enough understood today and is similar enough to currently existing rating and reinsurance approaches to make us reasonably certain that blocks of employer-sponsored plans could be risk-adjusted to the extent necessary to preclude risk selection by carriers. That is, a risk adjuster could be developed and implemented which would effectively eliminate the financial rewards for risk selection and the negative impact of adverse selection to a low enough level that the cost of selecting risks would outweigh any remaining financial advantage. This result can be achieved because within almost any employer group, healthy lives will be combined with unhealthy lives. This co-mingling of health status reduces the variability of costs per insured between different employer groups, and therefore between health plans as well. Furthermore, since these individuals have not joined together just to purchase health insurance, the carrier can estimate their costs as if they were random draws from a large population with similar characteristics.

The same statement cannot be made with assurance for insured populations where the choice of plan is made on an individual basis. In this situation, certain plans (such as fee-for-service plans) could be significantly more attractive to less healthy individuals, and the variation of cost per insured between plans could be significantly greater than when most employees of any given employer enroll within one plan. I personally expect risk adjusters to someday be capable of such financial balancing, but as of today, there is no research or evidence to assure us that risk adjusters currently being proposed would be accurate enough to protect carriers from the adverse selection that can result within a purchasing cooperative where individuals are allowed to choose any plan they want.

In order to address these and other issues, further research should be conducted in order to identify those risk assessment and risk adjustment methods that can effectively deal with the concerns of insureds, carriers and regulators.

Because of the far-reaching impact these risk adjusters would have on premiums and the solvency of health plans, HIAA is conducting a broad-based demonstration to evaluate the efficacy of different types of risk adjusters using actual member company data. We hope to have the demonstration project completed and a report available early next year.

If health care reform is implemented before adequate risk adjuster research can be completed, an interim risk adjustment mechanism should be implemented while additional research is being conducted.

In the interest of practicality and affordability, the interim mechanism should be based upon information readily available to carriers. The mechanism should adjust for differences in geography, family type, age, gender and industry, to the extent that carriers are not allowed to reflect risk differences based on these characteristics in their premium rates. The mechanism should also include a mandatory, broad-based reinsurance pool for spreading the cost of a limited number of high-cost, nondiscretionary conditions among all carriers and insureds.

HIAA does not support the use of pure community rating. If reforms are enacted that include pure community rating, there exists a strong need for a transition period using modified community rating as well as an interim risk adjustment mechanism. During this transition period, until adequate research can be completed, premiums should be determined separately for broad pools of insureds with differing risk characteristics, such as Medicare, Medicaid, early retirees, and active employees and their respective dependents.

#### **How Well Risk Adjusters Work With and Without Purchasing Cooperatives**

Just as community rating makes all insureds pay an average premium, health risk adjusters move everyone towards an ideal of having the same average claims cost. They do not make each insured's claims cost exactly equal to the average, however, because there will still be differences in provider practice patterns and efficiency (how well a plan manages the health care of its members and its overhead costs).

Health risk adjusters accomplish their task by transferring funds between health plans based on the health status of plan members. A simple risk adjuster based on the three risk classes shown in charts 1, 2 and 3 illustrates how. Let's assume that the premiums and costs illustrated in these three charts represent the average costs and premiums for an average health plan in the community and an average risk in the community for each of the three risk classes: low, average and high risk.

For every high-risk insured with expected claims cost of 300% of the average claims cost of all individuals in the community, the health plan would receive from the health risk adjustment pool a fixed amount of \$522 a month. When the health plan uses this fixed payment to reduce its expected cost of \$783 a month to \$261 a month, the new expected cost to the health plan of covering this high risk person reduces to the average cost in the community (assuming a perfect risk adjuster that fully adjusts to the average cost and assuming a perfectly efficient plan). Thus, the risk adjustment transfer effectively eliminates any incentive for the plan to avoid covering this high risk individual.

Likewise, for every low risk insured with expected claims cost of 60% of the average cost of all individuals in the community, the health plan would pay the health risk adjustment pool a fixed amount of \$104 a month. When the health plan uses this fixed payment to increase its expected cost of \$157 a month to \$261 a month, the new expected cost to the health plan of covering this low risk person increases to the average cost in the community.

Transfers to the pool for low risk members and transfers from the pool for high risk members are fixed by the methodology.

Every health plan pays and receives the same transfers for each member it covers, based on this methodology. A health plan operating within the health insurance purchasing cooperative would receive \$522 each month for every high risk insured. Any health plan operating outside the purchasing cooperative would also receive \$522 each month for every one of its high risk

insureds. Similarly, any health plan whether inside the purchasing cooperative or not, would pay \$104 a month to the pool for every low risk person it insured. In other words, the risk adjustment pooling mechanism works the same way no matter which plan the individual joins and regardless of whether a plan is inside or outside of a purchasing pool. Thus, mandatory purchasing alliances are not necessary in order for health risk adjustment mechanisms to work.

A real life example of this would be the New York risk adjustment mechanism. In New York the payments are defined the same way for every individual in every health plan.

One other issue related to purchasing cooperatives is the problem they create in the development of risk adjusters when employees are allowed to choose any plan they want. As mentioned earlier, it requires a much more sophisticated and/or accurate risk adjuster to solve this problem than it does to develop a risk adjuster that works in a market where employer-groups choose the plan.

### Summary

If we want insurers to compete on their ability to manage the cost of providing needed care, rather than on their ability to select the healthiest risks -- and we do -- then we have to make sure that the premiums insurers charge reflect only their administrative efficiency and their effectiveness in managing care; not variations in the underlying risk of the people they have enrolled.

This is what a risk adjustment mechanism is supposed to do. Whether a successful risk adjustment mechanism can be developed remains to be seen. Various methods have been proposed, but none has yet been tested for this purpose on an employed population. The HIAA has a group of actuaries looking at the problem, and they tell us that much depends on whether insurers are enrolling groups or individuals.

The difference in health care costs from individual to individual in a given year is extremely large. The variation among employer groups, even relatively small ones, is much less.

If individuals get to pick, as individuals, which health plan they want, their knowledge of their underlying health situation is likely to influence their choice of plan. Individuals with 2 or 3 chronic conditions, for example, are more likely to choose a conventional fee-for-service plan, to guarantee that they will be able to see all the specialists with whom they have already established relationships. Individuals with few health problems are more likely to choose a plan with a limited network of providers, especially if it's less expensive. This leads to a situation in which plans that offer greater choice of provider tend to get sicker enrollees than the average.

Theoretically, an effective risk adjustment mechanism would adjust for this biased selection. As a practical matter, however, our actuaries tell us that no system capable of adjusting for this kind of systematic biased selection has yet been developed and fully tested. Significant further research will be needed. HIAA research staff is working with member company actuaries to conduct the initial research and test models that would be applicable on an interim basis.

In this regard, risk characteristics of employer groups are better known and can be estimated with readily available demographic data. Until a better risk adjuster can be developed and demonstrated, we believe an interim mechanism can be implemented based on information that is currently available to carriers. The mechanism would adjust for differences in geography, family type, age, gender and industry to the extent these characteristics are not reflected in their premium rates. The mechanism would also include a mandatory reinsurance pool for spreading the cost of a limited number of high-cost,

nondiscretionary conditions among all carriers and insureds. A critical point is that this interim mechanism may work adequately only if insurers are enrolling employment-based groups of individuals. The interim mechanism may not be sufficient to adjust for the biased selection that is likely to occur if individuals choose their own health plans.

In conclusion, I want to emphasize that we support much more of the President's plan than we oppose. We want to be a responsible participant in the national health care debate and want to work with the Administration and Congress to develop national reform which achieves universal coverage, promotes individual responsibility and cost containment, preserves choice and maintains the quality of our health care system. In particular, we agree with much of what has been proposed for health risk adjusters and look forward to working with you to develop appropriate risk adjustment mechanisms that will help reforms to work.

## How Risk Adjustment Might Work in a Voluntary Purchasing Pool Environment

### Steps in the Risk Adjustment Process

The following scenario illustrates one way in which "risk adjustment" <sup>1</sup> might work across all health plans in a market area. The example assumes that small employers may purchase basic coverage directly from health plans, or they may arrange for coverage through a purchasing pool (regional health alliance or HIPC). All health plans, whether selling to individual employees through a purchasing pool or to employers outside the pool, are subject to uniform rating requirements and other regulations pertaining to basic benefit coverage.

Additional assumptions include:

- ▶ Employers and employees are required to purchase coverage for the basic plan.
- ▶ Each health plan/carrier quotes a flat community-rated premium for basic benefit coverage which is the price each individual enrollee must pay. The community-rated premium could alternatively be calculated per employee (primary insured).
- ▶ For simplicity, we describe an annual risk adjustment process, assuming there is no entry into or exit from plans during the year. In reality, the adjustment process would take place more frequently to address differing enrollment periods and other enrollment changes during the year.
- ▶ This example addresses only risk selection issues within the employed population. The subsidies necessary to provide health coverage to non-employed individuals and families are essentially a separate issue.

In this example, the entity overseeing the risk adjustment process is simply called the "risk adjustment administrator" (RA Administrator). The function of overseeing the risk adjustment process could be performed by a state agency or board, a state or regional purchasing pool, a private-sector enterprise, or some other organization.

We first describe the sequence of events in the risk adjustment process. We then present a simplified numerical example of the rate adjustment and revenue transfer calculations which are part of the process.

### Sequence of Events

#### Step 1      Health plans/carriers register with the RA Administrator.

- Several months before enrollment begins, all health plans/carriers who wish to sell coverage for basic benefits in the market area in the coming year must register with the RA Administrator, and must indicate whether they plan to sell this coverage through the purchasing pool or directly to small employer groups.
- As a condition, they must agree to all market rules, including participating in the risk-adjustment process (discussed earlier).

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<sup>1</sup> In the context of health reform, the term "risk adjustment" refers to a process of transferring (redistributing) premium income among health plans in a market area. Risk adjustment is needed in a reformed insurance market whenever rating restrictions prevent plans from charging premiums that reflect the expected costs the plans will incur.

**Step 2      The RA Administrator provides the information each health plan/carrier needs to develop its "standardized" community rate.**

The RA Administrator provides each plan/carrier with 3 standard pieces of information which the administrator will use in calculating revenue transfer amounts for each plan:

- definitions of the risk classification categories;
- the "relative risk factors" for each risk category; and
- the reference premium amount upon which the transfer amounts will be based. The reference premium could be last year's average premium in the community trended forward, or any another designated amount.

**Step 3      Each health plan/carrier develops its standardized community rate for the coming year.**

- Development of the plan's/carrier's "standardized" community rate starts with the community rate it would charge in the absence of a risk adjustment process. Adjustments are then made considering expected transfer payments and other contingencies associated with risk adjustment.
- Plans are free to use whatever method they choose to develop their standardized community rate. A plan may choose to use the information supplied by the RA Administrator (step 2) to calculate its expected transfer amount, and to adjust its community rate by the transfer amount. The rate would be adjusted upward if the plan/carrier expects to have to pay into the transfer pool, and downward if it expects to receive money from the transfer pool.
- Each plan/carrier may choose to further adjust its rate for pricing uncertainties associated with the risk adjustment process.
- The end result is the plan's "standardized" community rate, the rate enrollees (or their employers) will actually be charged for enrollment in the plan.

**Step 4      RA Administrator publishes rates.**

- The plans report their standardized community rates to the RA Administrator.
- The RA Administrator publishes the rates well before enrollment begins, together with information about whether the plan/carrier is marketing inside or outside the purchasing pool.

**Step 5      Enrollment.**

- Health plans/carriers market either directly to small employers, or to individual employees purchasing through the pool.
- Small employers evaluate options and decide to purchase coverage directly, or through the purchasing pool.
- Individual employees (inside) and small employers (outside) choose their preferred plans.



**Step 6      Health plans/carriers report actual enrollment data to the RA Administrator.**

- Plans/carriers selling inside the purchasing pool (HIPC) receive enrollment information from the pool administrator.
- All plans/carriers report to RA Administrator their total enrollment and distribution of enrollees by risk category.

**Step 7      RA Administrator calculates transfer amounts and administers revenue transfers.**

- The RA Administrator calculates each plan's/carrier's revenue transfer amount, based on the plan's/carrier's actual enrollment, the relative risk factors and the reference premium.
- For plans/carriers which must pay into the transfer pool (plans/carriers with actual relative risk lower than the community average), the RA Administrator bills the plan/carrier for the transfer amount.
- The RA Administrator pays out the transfer amounts to the plans/carriers which receive money from the transfer pool (plans/carrier which have actual relative risk greater than the community average).
- Theoretically, the risk adjustment process aims for a zero balance in the transfer pool in each period – transfers in should equal the transfers out. In practice, neither the plans/carriers nor the RA Administrator have perfect knowledge, and there may be changes in total enrollment and enrollee distribution by risk class in the community during the year. To ensure that the transfer pool has sufficient funds (remains solvent), the transfer amounts could be adjusted, or another source of funds could be tapped to create a reserve upon which the transfer pool could draw if needed.

**Attached (Attachment B) is a simplified numerical example of how this risk adjustment process would work in practice.**

**How Risk Adjustment Might Work  
in a Voluntary Purchasing Pool Environment**

**A Simplified Numerical Example**

*NOTE: This example is intended solely to illustrate the steps in the risk adjustment process described above. Other approaches to risk adjustment are possible. Further, the risk categories and assigned relative risk factors used here are arbitrary and purely illustrative.*

**Step 1      Health plans/carriers register with the RA Administrator.**

Three health plans/carriers register with the RA Administrator: Plan A, Plan B, and Plan C. These are the only plans/carriers in the community (offering basic benefit coverage), and together they cover all 20,000 members of the community.

**Step 2      The RA Administrator provides the information each health plan/carrier needs to standardize its community rate.**

**A. Risk categories.**

The RA Administrator tells the health plans/carriers there are three risk categories:

Category Definitions

Category 1

Category 2

Category 3

**B. Relative risk factors.**

The RA Administrator tells the plans/carriers the relative risk factors for each category:

Relative Risk Factors

Category 1 - 0.6

Category 2 - 0.8

Category 3 - 1.6

## C. Reference premium.

The RA Administrator tells the plans/carriers that the reference premium for calculating transfer amounts is \$200. The reference premium can be fixed at any reasonable amount. One choice could be the RA Administrator's estimate of last year's average cost per person for the community as a whole, trended forward. Another option is an estimate of the average cost per person of the more efficient plans/carriers.

**Step 3 Each health plan/carrier develops its standardized community rate for the coming year.**

*NOTE: Plans will in fact, use whatever method they choose to develop their "standardized community rate," which is the rate enrollees or their employers will actually be charged for enrollment in the plan. (We ignore here any mark-up the HIPC might add to fund its operations.) This example illustrates one way the plans might approach developing their standardized community rates.*

## A. Expected enrollment.

The three plans/carriers expect the following enrollment:

Expected 1994 Enrollment (number of enrollees)				
Plan	Category 1	Category 2	Category 3	Total
A	2000	5000	1000	8000
B	1000	3000	2000	6000
C	1000	2000	3000	6000
Whole Community	4000	10,000	6000	20,000

## B. Unadjusted flat community rate.

Based on plan historical experience, expected medical inflation, etc, plan/carrier actuaries calculate the flat community rate the plan/carrier would charge in the absence of rating restrictions for the expected enrollment (expected risks). We call this the "unadjusted" community rate.

Unadjusted Community Rate

Plan A - \$190

Plan B - \$210

Plan C - \$240

## C. Plan/carrier expected relative risk (average risk relative to whole community)

Based on the enrollee category relative risk factors supplied by the RA Administrator, plan/carrier actuaries calculate the plan's expected relative risk. The average risk for the whole community is 1.00.

*The expected relative risk is a weighted average of the category relative risk factors, where the weights are the proportion of enrollees expected in each category.*

$$\text{Plan A: } (2000 (0.6) + 5000 (0.8) + 1000 (1.6)) / 8000 = 0.85000$$

$$\text{Plan B: } (1000 (0.6) + 3000 (0.8) + 2000 (1.6)) / 6000 = 1.03333^2$$

$$\text{Plan C: } (1000 (0.6) + 2000 (0.8) + 3000 (1.6)) / 6000 = 1.16667^2$$

\* rounded

Expected Relative Risk

Plan A - 0.85000

Plan B - 1.03333

Plan C - 1.16667

## D. Expected transfer amounts per enrollee.

*Each plan's expected per enrollee transfer amount is equal to:*

*(1 - plan's expected relative risk) (reference premium)*

$$\text{Plan A: } (1 - 0.85000) (200.00) = 30.00$$

$$\text{Plan B: } (1 - 1.03333) (200.00) = - 6.67^2$$

$$\text{Plan C: } (1 - 1.16667) (200.00) = - 33.33^2$$

\* rounded

Expected Transfer Amount

Plan A - \$30.00

Plan B - (\$6.67)

Plan C - (\$33.33)

## E. Developing standardized community rate.

Each plan's/carrier's standardized community rate equals its unadjusted community rate plus the expected transfer amount, further adjusted for other contingencies. In this example, we do not include an adjustment for other contingencies.

$$\text{Plan A: } \$190 + 30.00 = \$220.00$$

$$\text{Plan B: } \$210 - 6.67 = \$203.33$$

$$\text{Plan C: } \$240 - 33.33 = \$206.67$$

Standardized Community Rate

Plan A - \$220.00

Plan B - \$203.33

Plan C - \$206.67

These are the rates that each plan/carrier charges per person enrolled.

**Step 4** RA Administrator publishes rates.

**Step 5** Enrollment.

**Step 6** Health plans/carriers report actual enrollment data to the RA Administrator.

The plans/carriers report the following enrollment:

Actual 1994 Enrollment (number of enrollees)				
Plan	Category 1	Category 2	Category 3	Total
A	1000	3000	1000	5000
B	1500	4500	2500	8500
C	1500	2500	2500	6500
Whole Community	4000	10,000	6000	20,000

**Step 7 RA Administrator calculates transfer amounts and administers revenue transfers.**

**A. Actual relative risk.**

RA Administrator calculates each plan's/carrier's actual relative risk:

*The actual relative risk is a weighted average of the category relative risk factors, weighted by the actual proportion of enrollees in each category.*

$$\text{Plan A: } (1000 (0.6) + 3000 (0.8) + 1000 (1.6)) / 5000 = 0.92000$$

$$\text{Plan B: } (1500 (0.6) + 4500 (0.8) + 2500 (1.6)) / 8500 = 1.00000$$

$$\text{Plan C: } (1500 (0.6) + 2500 (0.8) + 2500 (1.6)) / 6500 = 1.06154$$

\* rounded

Actual Relative Risk

Plan A - 0.92000

Plan B - 1.00000

Plan C - 1.06154

**B. Transfer amounts.**

The transfer amount for each plan/carrier is calculated according to the following formula:

Transfer Amount = (1 - plan actual relative risk) (reference premium) (# enrollees)

$$\text{Plan A: } (1 - 0.92000) (\$200) (5000) = \$80,000^*$$

$$\text{Plan B: } (1 - 1.00000) (\$200) (8500) = 0$$

$$\text{Plan C: } (1 - 1.06154) (\$200) (6500) = (\$80,002)^*$$

\* transfers do not add to \$0 because of rounding.

**C. Revenue transfers.**

The RA Administrator instructs Plan A to pay into the pool \$80,000. The RA Administrator then pays out \$80,002 to Plan C. Plan B, in our example, transfers neither in nor out.

**Risk Adjusters and the Health Security Act**  
by P. Anthony Hammond, ASA, MAAA

**SUMMARY**

The proposed Act provides for development of a fully prospective, zero sum, risk adjustment mechanism based on factors related to demographics, health status, area of residence, socioeconomic status and, possibly, welfare status. Although the methodology for the mechanism is to be promulgated by the National Health Board, it is supposed to address regional differences in health care cost and utilization. Shortfalls in transfer payments as a result of actual enrollment being different from expected can be made up by adjustments to next year's transfer payments. Regional alliances are required to apply the system to health plan payments.

The Act requires the National Health Board to establish a mandatory reinsurance mechanism that applies to all regional alliance health plans if it determines that an adequate system for prospective risk adjustment cannot be developed by April 1, 1995. The mechanism would reinsure plans for specified classes of high-cost enrollees, treatments, or diagnoses. The reinsurance premiums may be either prospective or retrospective. The reinsurance mechanism may be reduced or discontinued when a more adequate prospective risk adjustment mechanism is developed. States are tasked with implementing the reinsurance mechanism.

**ANALYSIS**

The description of this mechanism is reasonably compatible with the HIAA Risk Adjustment Workgroup recommendations for an interim risk adjustment mechanism.

The Act allows for continual development of an adequate risk adjustment mechanism. Defining what is meant by an "adequate" risk adjuster will be important.

The Act requires development of a zero sum mechanism and allows for shortfalls of transfer payments when enrollment estimates are different from actual, but there can be other reasons for shortfalls. The transfers based on the relative risk factors and reinsurance payments are unlikely to be perfect because these are estimates subject to statistical variation and prediction error. Shortfalls could be generated from using these estimated values as easily as from enrollment estimates. Thus, the Act should not limit the carryover for shortfalls to just differences in enrollment projections.

The question of whether any risk adjuster working in an individual choice environment is adequate to compensate for individual adverse selection has still not yet been answered. This is all the more important when all plans are forced to participate in the regional alliance.

One concern would be whether the reinsurance premiums are prospective or retrospective. They should be prospective. New York handles this by charging a \$5 per person premium prospectively to establish the reinsurance fund which then makes payments to plans based on occurrences of certain high cost conditions. A similar approach where premiums are prospective and payments are retrospective would be reasonable.

Making the risk adjustment mechanism dependent on services to disadvantaged populations would be a mistake. Risk adjustment factors that reflected these services explicitly would probably be very subjective. Besides, the health services needed when one has appendicitis should be unrelated to how much access one has to the system or what barriers might exist to obtaining health care.

Requiring risk adjustment factors to specifically consider certain illnesses--such as mental illness--implies subjective prejudices regarding what conditions most reasonably reflect the health status of individuals. Instead, factors should be based on fair, objective criteria, applied consistently, which identifies those conditions that would be most predictive of health status.

Risk adjustments should not be based on factors which do not directly relate to health status, e.g., barriers to access.

## References to Risk Adjustment in Proposed Health Security Act

## Title I: Health Care Security

- §1203: State responsibilities relating to health plans.
- §1351: Payment to regional alliance health plans.
- §1541: Development of a risk adjustment and reinsurance methodology.
- §1542: Incentives to enroll disadvantaged groups.
- §1543: Advisory committee.
- §1544: Research and demonstrations.
- §1545: Technical assistance to States and alliances.

## Title V: Quality and Consumer Protection

- §5003: National measures of quality performance.
- §5120: Health information system privacy standard.

## Title I: Health Care Security

## Subtitle C: State Responsibilities

- §1203: STATE RESPONSIBILITIES RELATING TO HEALTH PLANS.
- (g) Implementation of Mandatory Reinsurance System. If the risk adjustment and reinsurance methodology developed under section 1541 includes a mandatory reinsurance system, each participating State shall establish a reinsurance program consistent with such methodology and any additional standards established by the Board.

## Subtitle D: Health Alliances

- §1351: PAYMENT TO REGIONAL ALLIANCE HEALTH PLANS.
- (c) Application of Risk Adjustment and Reinsurance Methodology. Each regional alliance shall use the risk adjustment methodology developed under section 1541 in making payments to regional alliance health plans under this section, except as provided in section 1542.

## Subtitle F: Federal Responsibilities

## PART 1: NATIONAL HEALTH BOARD

## Subpart E: Risk Adjustment and Reinsurance Methodology for Payment of Plans

- §1541: DEVELOPMENT OF A RISK ADJUSTMENT AND REINSURANCE METHODOLOGY.
- (a) Development
  - (1) Initial development. Not later than April 1, 1995, the Board shall develop a risk adjustment and reinsurance methodology in accordance with this subpart.
  - (2) Improvements. The Board shall make such improvements in such methodology as may be appropriate to achieve the purposes described in subsection (b)(1).
- (b) Methodology
  - (1) Purposes. Such methodology shall provide for the adjustment of payments to regional alliance health plans for the purposes of:
    - (A) assuring that payments to such plans reflect the expected relative utilization and expenditures for such services by each plan's enrollees compared to the average utilization and expenditures for regional alliance eligible individuals, and
    - (B) protecting health plans that enroll a disproportionate share of regional alliance eligible individuals with respect to whom expected utilization of health care services (included in the comprehensive benefit package) and expected health care expenditures for such services are greater than the average level of such utilization



- and expenditures for regional alliance eligible individuals.
- (2) Factors to be considered. In developing such methodology, the Board shall take into account the following factors:
    - (A) Demographic characteristics
    - (B) Health status
    - (C) Geographic area of residence
    - (D) Socio-economic status
    - (E) Subject to paragraph (5):
      - (i) the proportion of enrollees who are SSI recipients and
      - (ii) the proportion of enrollees who are AFDC recipients.
    - (F) Any other factors determined by the Board to be material to the purposes described in paragraph (1).
  - (3) Zero sum. The methodology shall assure that the total payments to health plans by the regional alliance after application of the methodology are the same as the amount of payments that would have been made without application of the methodology.
  - (4) Prospective adjustment of payments. The methodology, to the extent possible and except in the case of a mandatory reinsurance system described in subsection (b), shall be applied in manner that provides for the prospective adjustment of payments to health plans.
  - (5) Treatment of SSI/AFDC adjustment. The Board is not required to apply the factor described in clause (i) or (ii) of paragraph (2)(E) if the Board determines that the application of the other risk adjustment factors described in paragraph (2) is sufficient to adjust premiums to take into account the enrollment in plans of AFDC recipients and SSI recipients.
  - (6) Special consideration for mental illness. In developing the methodology under this section, the Board shall give consideration to the unique problems of adjusting payments to health plans with respect to individuals with mental illness.
  - (7) Special consideration for veterans, military, and indian health plans. In developing the methodology under this section, the Board shall give consideration to the special enrollment and funding provisions relating to plans described in section 1004(b).
  - (8) Adjustment to account for use of estimates. Subject to section 1346(b)(3) (relating to establishment of regional alliance reserve funds), if the total payments made by a regional alliance to all regional alliance health plans in a year under section 1324(c) exceeds, or is less than, the total of such payments estimated by the alliance in the application of the methodology under this subsection, because of a difference between:
    - (A) the alliance's estimate of the distribution of enrolled families in different risk categories (assumed in the application of risk factors under this subsection in making payments to regional alliance health plans), and
    - (B) the actual distribution of such enrolled families in such categories,
 the methodology under this subsection shall provide for an adjustment in the application of such methodology in the second succeeding year in a manner that would reduce, or increase, respectively, by the amount of such excess (or deficit) the total of such payments made by the alliance to all such plans.
- (c) Mandatory Reinsurance
- (1) In general. The methodology developed under this section may include a system of mandatory reinsurance, but may not include a system of voluntary reinsurance.
  - (2) Requirement in certain cases. If the Board determines that an adequate system of prospective adjustment of payments to health plans to account for the health status of individuals enrolled by regional alliance

health plans cannot be developed (and ready for implementation) by the date specified in subsection (a)(1), the Board shall include a mandatory reinsurance system as a component of the methodology. The Board may thereafter reduce or eliminate such a system at such time as the Board determines that an adequate prospective payment adjustment for health status has been developed and is ready for implementation.

- (3) Reinsurance system. The Board, in developing the methodology for a mandatory reinsurance system under this subsection, shall:
  - (A) provide for health plans to make payments to state-established reinsurance programs for the purpose of reinsuring part or all of the health care expenses for items and services included in the comprehensive benefit package for specified classes of high-cost enrollees or specified high-cost treatments or diagnoses; and
  - (B) specify the manner of creation, structure, and operation of the system in each State, including:
    - (i) the manner (which may be prospective or retrospective) in which health plans make payments to the system, and
    - (ii) the type and level of reinsurance coverage provided by the system.
  - (c) Confidentiality of Information. The methodology shall be developed in a manner consistent with privacy standards promulgated under section 5102(a). In developing such standards, the Board shall take into account any potential need of alliances for certain individually identifiable health information in order to carry out risk-adjustment and reinsurance activities under this Act, but only to the minimum extent necessary to carry out such activities and with protections provided to minimize the identification of the individuals to whom the information relates.

#### §1542: INCENTIVES TO ENROLL DISADVANTAGED GROUPS.

The Board shall establish standards under which States may provide (under section 1203(e)(3)) for an adjustment in the risk-adjustment methodology developed under section 1541 in order to provide a financial incentive for regional alliance health plans to enroll individuals who are members of disadvantaged groups.

#### §1543: ADVISORY COMMITTEE

- (a) In General. The Board shall establish an advisory committee to provide technical advice and recommendations regarding the development and modification of the risk adjustment and reinsurance methodology developed under this part.
- (b) Composition. Such advisory committee shall consist of 15 individuals and shall include individuals who are representative of health plans, regional alliances, consumers, experts, employers, and health providers.

#### §1544: RESEARCH AND DEMONSTRATIONS.

The Secretary shall conduct and support research and demonstration projects to develop and improve, on a continuing basis, the risk adjustment and reinsurance methodology under this subpart.

#### §1545: TECHNICAL ASSISTANCE TO STATES AND ALLIANCES.

The Board shall provide technical assistance to States and regional alliances in implementing the methodology developed under this subpart.

### Title V: Quality and Consumer Protection

#### Subtitle B: Information Systems, Privacy, and Administrative Simplification

##### PART 2: PRIVACY OF INFORMATION

#### §5120. HEALTH INFORMATION SYSTEM PRIVACY STANDARDS.

- (c) Principles. The standards established under subsection (a) shall incorporate the following principles:
- (3) Risk adjustment. No individually identifiable health information may be provided by a health plan to a regional alliance or a corporate alliance for the purpose of setting premiums based on risk adjustment factors.

Chairman STARK. Mr. Bachofer.

**STATEMENT OF HENRY BACHOFER, EXECUTIVE DIRECTOR,  
CENTER FOR HEALTH ECONOMICS AND POLICY RESEARCH**

Mr. BACHOFER. I am here as Executive Director of the Center for Health Economics and Policy Research of the Blue Cross and Blue Shield Association, the coordinating organization for the 69 independent Blue Cross and Blue Shield plans.

I appreciate this opportunity to testify on the important, technical issue, of risk adjustment. We believe the best, most effective strategy to contain costs while meeting the needs of patients and consumers is the enactment of reforms that leads to true price competition for the first time in the financing and delivery of health care in this country.

In a truly competitive market, of course, health plans would compete on the basis of their ability to manage costs, not their ability to avoid those in poor health or those who are most in need of medical care.

Chairman STARK. You mean compete for a standard, defined benefit package?

Mr. BACHOFER. Yes.

Chairman STARK. Flat price?

Mr. BACHOFER. That is correct.

Chairman STARK. No ands, ifs, or buts? That is how you see competition working?

Mr. BACHOFER. That is the ideal in a competitive market. What our studies found consistently is that all health plans are not equally likely to cover higher risk subscribers. It is not uncommon to find differences in risk of 20 percent, 30 percent, or more across health plans operating in a single market.

Risk adjustment then is needed to level out those differences in risk and establish a level playing field. Several elements of the President's reform proposal are problematic without a proven reliable method for adjusting for differences in risk. These include first the requirement that each health plan set a single community rate that applies to individuals and all sizes of employers.

Second, the requirement that all coverage be purchased on an individual and not a group basis.

Third, the application of premium caps to limit the rate of increase and the level of premiums; and finally—

Chairman STARK. Wait. Wait. Third, you just mentioned, like the application of premium caps, you mean you favor that?

Mr. BACHOFER. We see without a reliable method of adjusting for risk that is particularly problematic.

Chairman STARK. Wait a minute. You have a bid. We start out. Every individual in the District of Columbia is going to be offered an identical plan, maybe several types of plans.

Mr. BACHOFER. That is a standardized benefit.

Chairman STARK. Here for \$50 a month, there for \$60 a month. Same benefits.

Now next year you were not going to let them bid again? Everything after the initial bid is an inflator?

Mr. BACHOFER. Every year there would be a repeat of that process.

Chairman STARK. Why do you need a premium cap?

Mr. BACHOFER. We don't believe you do.

Chairman STARK. You said you wanted the application of premium caps. Either you want it or you do not?

Mr. BACHOFER. We do not. What I believe I was trying to say was that there are several features in the President's proposal that are particularly problematic if you do not have a risk adjuster and the premium caps would be one of those.

Chairman STARK. OK. All right.

Mr. BACHOFER. The fourth of those points, those areas is the ability of health alliances to exclude any health plan with costs exceeding the average by more than 20 percent.

Chairman STARK. This is a problem for you?

Mr. BACHOFER. That is a problem for us.

Chairman STARK. Why would anybody choose a health plan whose premium is 80 percent higher?

Mr. BACHOFER. There will be differences across health plans in terms of the provider network they include, the customer service levels they provide, the types of utilization management techniques, whether they have a gatekeeper, on and on.

Chairman STARK. OK.

Mr. BACHOFER. We do not believe at this time that the state-of-the-art in risk adjustment can today support those four elements of the President's proposals I just reviewed. Many currently available techniques have promise but that promise is far from being realized. In the best summary of the state-of-the-art is that it is in its infancy.

Chairman STARK. Your group has all kinds of Ph.D.s in it, in number crunchers, so you can tell me you will match your scientific credentials against Thorpe and his gang when you make this statement?

Mr. BACHOFER. We have been working with both in our own group which has another—a number of economists in it as well as people like Harold Luft, others who reviewed the work we have been doing.

Chairman STARK. Who?

Mr. BACHOFER. Harold Luft who testified earlier.

Chairman STARK. All right.

Mr. BACHOFER. For example, in a comparison of products virtually identical in terms of benefits and provider networks, we find demographic factors account for less than 20 percent of the difference in actual costs between the two groups. When we look at things like prior non-discretionary hospitalization, our best models are predicting only 30 to 35 percent of the difference in actual costs. So we feel we have a long way to go with those kinds of methods before there is an adequate risk adjuster.

We have also looked, however, at actuarial models using different approaches to risk management. Those appear to be better at predicting high cost cases, but require extensive data and are expensive to implement.

We also looked at the New York model, for example. We feel—

Chairman STARK. Wait a minute here. You like community rating but want to limit it to groups with less than 100 members?

Mr. BACHOFER. That is correct. We are proposing that—

Chairman STARK. Why?

Mr. BACHOFER. In part because of the limitations of available risk adjustment methods that by dealing with community rating in the small group at the individual end of the markets, we are really dealing with that part of the market where people have the greatest barriers to obtaining coverage. It limits the problems that arise.

Chairman STARK. You want individuals to make the choice of insurance, but only if they are in groups of less than a hundred?

Mr. BACHOFER. We are also urging in the near term in order to limit the risk of—

Chairman STARK. You are saying all coverage purchases on an individual not group basis, you mean for groups of people who cannot find 99 friends?

Mr. BACHOFER. Right. What we are actually saying is there are two elements that we feel should be included to recognize the limitations.

Chairman STARK. Why not make it individual for everybody?

Mr. BACHOFER. We are actually arguing for in the small group market, it applies on an employer basis, on a group basis. Until—

Chairman STARK. Why can't it be everybody?

Mr. BACHOFER. Because we feel if you move to individual choice immediately in that end of the market, there would be significant problems with selection bias and adverse selection that would not be corrected because we do not have an available risk adjuster today.

Chairman STARK. You think people being locked into what their employer offers is a good thing?

Mr. BACHOFER. We feel if you provide all— a standardization of benefits and require all employers to comply with guaranteed issue, guaranteed renewal, you will substantially increase the options available to both employers and their employees. We also feel you could expand within that framework the options for individual choice so small employers could, like large employers, offer their employees a choice of multiple benefit plans.

We do feel risk adjustment methods have some potential, but we have a long ways to go before we understand whether that risk adjustment method in New York will actually be effective. We have already covered some of the next points I would like to make but to review that briefly, our bottom line is that today we can only at best partially correct for differences in risk among competing health plans.

As a result, we feel reform should respect the limits of available methods by first limiting community rating to groups with fewer than 100 members; second, retaining a role for the employer in choosing the health plan for their employees, although we believe you could expand the opportunities for individual choice; third, not allowing alliances if they are obtained as part of reform to exclude health plans on the basis of price and finally relying on competition, not premium caps, to control costs.

One final comment I would like to make is that—in response to comments by the previous panel which may have left the impression that an alliance is needed to perform risk adjustment, this is not the case. We believe risk adjustment can and in our view ought to be performed outside of the alliance as is the case in New York where they are proceeding with their proposal.

Mr. Chairman, thank you again for this opportunity. I will do my best to answer what questions you may have.

[The prepared statement follows:]

**TESTIMONY OF HENRY BACHOFER  
EXECUTIVE DIRECTOR  
CENTER FOR HEALTH ECONOMICS AND POLICY RESEARCH**

Mr. Chairman, and members of the committee, I am Henry Bachofer, Executive Director of the Center for Health Economics and Policy Research of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million people. I appreciate the opportunity to testify on the important issue of risk adjustment.

We believe that the best, most effective strategy to contain costs while meeting the needs of patients and consumers is the enactment of reforms that would lead to true price competition -- for the first time -- in the financing and delivery of health care in this country. Price competition, not price controls, will lower costs and deliver better value for consumers. Risk adjustment is the means of establishing a level playing field so that the premiums set by health plans reflect their ability to manage costs -- not their ability to avoid risk.

**Why is risk adjustment needed?**

Our studies have consistently found that all health plans are not equally likely to cover higher risk subscribers. In our studies, it is not uncommon to find differences in risk of 20 percent, 30 percent or more across insurers and Health Maintenance Organizations (HMOs). Several elements of the President's reform proposals make these differences in risk significant:

1. The requirement that a single community rate be set by each health plan that applies to individuals and all sizes of employers.
2. The requirement that all coverage is purchased on an individual -- and not a group -- basis.



3. The application of premium caps to limit the rate of increase and level of premiums.
4. The ability of health alliances to exclude any health plan whose premium is more than 20 higher than the 'average' plan.

Under these rules, it will be difficult for health plans that have been selected by older or less healthy subscribers to compete on a level playing field. The purpose of risk adjustment is to even out differences in premiums that result from differences in risk so that health plans can compete on the basis of their proven ability to manage costs.

No known method of risk adjustment can fully correct for differences in risk across carriers. The lack of an effective risk adjustment method does not mean that we cannot move ahead with reforms designed to make health care more competitive. Recognizing the limitations of available methods of risk adjustment, reform should:

1. limit community rating to groups with fewer than 100 members;
2. retain a role for employers in choosing a health plan for their employees while expanding opportunities for individual choice;
3. not allow alliances -- if they are retained as part of reform -- to exclude health plans on the basis of price; and,
4. rely on real competition based on cost, quality and consumer satisfaction -- and not premium caps -- to control costs while offering greater value for consumers.

Within these limits, we believe plans can compensate for adverse selection through more effective management of costs. Even though we believe that many Blue Cross and Blue Shield Plans have suffered from adverse selection, they have been able to offer a competitive premium in their markets for a number of reasons.

First, most insurance has been sold on a group, and not individual, basis. Having an effective method of risk adjustment is most critical when individuals choose their own health plans. When employers select a carrier, risk adjustment, while still important, is less critical.

Second, we have traditionally relied on provider payment methods that have resulted in lower claims costs than our competitors. Increasingly, Plans are relying on fixed, negotiated fee schedules to pay both hospitals and physicians. These methods of payment allow a health plan to more effectively manage its risk.

Third, we have very successfully managed utilization, particularly inpatient hospital utilization. During the 1980s, the number of inpatient hospital days per 1,000 Blue Cross and Blue Shield subscribers has fallen 40 percent, reaching 430 in the most recent quarter for which data are available.

Fourth, we have aggressively developed and marketed more efficient products that rely on selected networks of providers. Today, more than 35 percent of our members are enrolled in products that deliver the majority of care through a selected network of hospitals and/or doctors.

More recently, Plans have pioneered in the development and application of information systems that are able to provide detailed profiles of provider practice patterns. These data are being used to guide the selection of providers for networks by identifying those who efficiently use resources, to improve the

efficiency and effectiveness of health care delivery, and to create stronger incentives for providers to manage costs while improving quality and maintaining or increasing patient satisfaction.

And finally, Plans are now developing partnerships with vertically integrated health care systems linking doctors and hospitals in which the providers accept greater responsibility for managing per capita costs.

This experience suggests that, in the short run, reform can proceed even if we cannot correct completely for differences in risk among health plans. We can proceed, provided we do so carefully and avoid reforms that run a substantial risk of failure unless accompanied by effective methods of risk adjustment. Over the long run, it is important to develop better methods of risk adjustment so that consumers who have chosen more efficient and effective plans will benefit from their choice.

**Is risk adjustment, as it exists today, up to the task?**

The Administration has emphasized that a risk adjuster will address the problems of risk selection. We support risk adjustment, but do not believe that risk adjustment methods will be sufficiently advanced to solve the problem. We have developed or evaluated several methods of risk adjustment over the past several years. These methods have included three substantially different techniques to measure risk:

1. Simple demographic models, relying on age, sex, employment status and family size.
2. Risk adjustment techniques that consider non-elective hospitalization in the prior year or chronic medical conditions for which subscribers have sought

treatment. These techniques rely on Diagnostic Cost Groups and Ambulatory Cost Groups.

3. Risk adjustment techniques that rely on actuarial evaluation of the "risk" presented by an individual or family subscriber.

The best summary is that several risk adjustment techniques have promise, but that promise is far from being realized.

The impact of age and sex on costs has long been recognized. For example, a person age 55 will, on average, incur costs that are four times higher than a person age 25. However, these simple demographic adjustments account for only a small part of the difference in premiums that can be attributed to risk selection.

For example, in a comparison of products that are virtually identical in terms of benefits and provider networks, demographic factors accounted for less than 20 percent of the difference in actual costs.

When additional information is considered, specifically a person's non-discretionary use of health services in prior years, we can account for more of the difference in costs. However, the predictive power of these models continues to be low. In the same study whose results were just cited, even our best methods predicted a difference in costs that was 35 percent or less of the difference in actual costs. However, this result is from a single study of differences in the costs of products offered by the same carrier. We believe that these models will be account for even less of the difference in costs across products offered by different carriers in the small group and individual market.

Actuarial models appear to be promising. In a very different approach to risk measurement, we asked actuaries to assign individuals and families to various risk

classes based on their age and sex, prior use of medical services, and selected medical conditions that are associated with higher use of medical care. These methods were much better at predicting whether a person would incur costs in the top 20 percent of all subscribers than methods that relied solely on self-reported health status. However, the application of these techniques requires a substantial amount of accurate data on each subscriber and the judgment of carefully trained actuaries.

States are currently experimenting with other approaches. A number of solutions to the problem of risk adjustment have been devised, but none have yet proven themselves. Some of these techniques appear promising. For example, New York state has developed a risk adjustment method that relies on basic demographic characteristics and a "high cost medical condition" pool. This approach differs from re-insurance approaches in that payments are made from the "high cost medical condition" pool only for a limited number of carefully defined medical conditions. Payments are not made for any subscriber who incurs high costs. This approach should, in principle, make adjustments for differences in the number or high risk subscribers enrolled in each health plan without rewarding health plans that less efficiently or effectively manage high cost conditions. However, we still lack sufficient experience to evaluate whether it will be effective.

### **What is the solution?**

The bottom line is that we can today partially correct for differences in risk among competing health plans. However, we need to do better. Unless an effective method of risk adjustment is developed, plans serving higher risk groups and communities could be forced from the market. In practical terms, this means that we should proceed cautiously with reforms that may make it impossible for health

plans with higher risk subscribers to compete on a level playing field. Among the reforms that should be approached with caution are the immediate adoption of community rating for employers of virtually any size and the requirement of unlimited individual choice of health plan.

Our limited ability to measure risk today should be seen as a challenge for health care reform. This challenge is not insurmountable. The limitations of existing risk adjustment methods do not mean that significant reform needs to be delayed. It should not be forgotten that the purpose of risk adjustment is to reduce the ability of health plans to compete by selecting good risks or, more accurately, by avoiding those in poor health. Risk adjustment contributes to this goal by limiting the advantages that accrue to health plans that attract good risks. Fortunately, risk adjustment is not the only, or even the most important, means of limiting risk selection.

We believe that strict federal standards for the market conduct of insurers are an essential step to limit the ability of health plans to compete by selecting good risks. Strict standards are the first and most important step toward reshaping the health care market -- and assuring fairness to consumers. Federal standards defining an Accountable Health Plan (AHPs) should:

1. Require insurers to accept everyone regardless of their health status or employment;
2. Strictly limit the length and use of waiting periods for pre-existing conditions and prohibit them entirely for people who have been continuously covered;

3. Prohibit insurers from dropping people or groups when someone gets sick, and require insurers to offer continued coverage when a person loses his or her job;
4. Require insurers to set premiums fairly and not penalize people who are sick or older; and,
5. Require insurers to comply with requirements for administrative simplification, including increased reliance on electronic data interchange and conformity to standards.

These same strict standards must apply to more than insurers and HMOs. Self-funded plans must play by the same rules and be held to the same standards as AHPs.

In addition, the federal government should adopt cost-containment standards that also limit opportunities for risk selection and that lead health plans to compete on the basis of cost, quality and customer satisfaction. The federal government should:

1. Standardize health benefit designs. A limited number of standardized benefit designs will allow consumers to easily compare products, although we do not believe a single standardized benefit design will be workable. These benefit packages should be the same in all states, and should be the same for large and small employers, as well as individuals and families who do not purchase coverage through an employer.
2. Provide consumers with standardized data on a health plan's quality of care and subscriber satisfaction rating. Standardized measures of quality and subscriber satisfaction will enable consumers to select a health plan based on

quality and service, in addition to price. To hold administrative costs to a minimum and enable more meaningful comparisons, the federal government should develop standard measures that could be adopted by the states.

The limitations of risk adjustment methods also mean that, until more powerful risk adjustment methods are developed, community rating should be required only for individuals and small groups. We believe that community rating is essential to the development of truly competitive markets for health insurance.

For the same reason, we recommend that requirements for individual choice be expanded gradually. If small employers require help to administer their health benefits, voluntary purchasing cooperatives could be formed to allow small employers to offer their employees choice of health plans on an individual basis.

Finally, because variations in risk that cannot be corrected by available risk adjustment methods may cause premiums to vary widely, premium caps may fall unfairly on health plans that enroll older or sicker subscribers. In addition, allowing health alliances to exclude any health plan with premiums more than 20 percent above the average of all plans could exclude plans with higher risk subscribers but an excellent record of cost management and customer service. The absence of an effective risk adjustment methods means that health plans must be able to set premiums that are consistent with their expected costs without arbitrary limits imposed by either alliances or federal premium caps.



Chairman STARK. Are both of you in agreement, you both—Mr. Bykerk, do you have any quarrel with Mr. Bachofer's testimony?

Mr. BYKERK. As I understand it, we are very close to the same posture.

Chairman STARK. Mutual of Omaha stands ready to go toe-to-toe with any Blue Cross plan in the country under these rules?

Mr. BYKERK. I believe we are—you know, with property risk adjusters, the other market reform issues we have talked about, yes.

Chairman STARK. OK. You feel your members are all ready to go head-to-head with Aetna or Signa or—

Mr. BACHOFER. We reviewed the competitive position of the plans in a number of markets around the country and feel in the small group market we could proceed in the direction of community rating. We would prefer to have demographic adjustments in that rate to reflect differences in age. But we feel we could do that; yes.

Chairman STARK. Do you either have any objection if we make the alliances optional, voluntary? That doesn't trouble you?

Mr. BYKERK. We support voluntary alliances.

Mr. BACHOFER. We feel there may be a role for voluntary alliances, particularly for small employees in facilitating enrollment.

Chairman STARK. You want to open it up so anybody can be in there and bid using the standard benefit plan; correct?

Mr. BACHOFER. We feel that is essential.

Chairman STARK. Would you have any objection to Medicare being offered in those same markets under the same conditions?

Mr. BYKERK. To the extent that Medicare's reimbursement rates are developed in a different plan, never—

Chairman STARK. That has nothing to do with it. That is separate. You are not going to have anything to say about the Blue Cross reimbursement rates, are you?

Mr. BYKERK. Not specifically.

Chairman STARK. No. Why should you care how Medicare reimburses? Tell me—you just said you do not care—you are willing to compete with Blue Cross. Now let's say they have a different reimbursement structure for their part.

Mr. BYKERK. To the extent that Blue Cross organizations have governmental imposed discounts—

Chairman STARK. No. No. No. No. Wait a minute. Wait a minute. Let's start back. Let's review the bidding. You are willing to compete in Indiana with Blue Cross of Indiana; correct? You have no control over how Blue Cross of Indiana pays its hospitals, its doctors or whether it bids a discount rate for cataract surgery. You may do the same; correct? Doesn't trouble you, Mr. Bachofer, how they pay their providers?

Mr. BACHOFER. No. It is to be negotiated.

Chairman STARK. We are all building on the same benefit package here—why should you care for a minute because Mrs. Johnson and I are running Medicare? We want to bid or offer Medicare in Indiana. What difference does it make to you how we reimburse anybody? I am going to have to pay them if I want quality doctors. If I do not offer quality doctors and you do, people will come to your plan, won't they?

Mr. BYKERK. If the structure is set up so you are inducing doctors to come in to compete on the basis of what you are paying them, I guess I have less of a problem.

Chairman STARK. You know what we do now? We don't induce anybody. We just pay them. There is no law that says a doctor has to accept Medicare patients.

Mr. BYKERK. That is true. That is true.

Chairman STARK. I gather you would not object then? Medicare could come in and compete with you; is that fair?

Mr. BYKERK. I hesitate to agree with you on that in that we have been a major player in the individual market. We are at the bottom of the cost shift slide because we have very little control over our—what we pay to providers. Some of that is coming from Medicare.

Chairman STARK. But Medicare is down the line anyway. Now I am saying we want to offer it to people under 65 who cannot get insurance. We are talking about the same plan. Voluntary. You know, think about that a minute why I ask Mr. Bachofer why he would object. Maybe he wouldn't. I gather he would welcome us into the arena.

Mr. BACHOFER. I could see a couple of problems that might arise if you allowed Medicare to compete against private carriers or private health plans. The first of those is we are not entirely sure what direction the selection will work in. There is a lot of speculation that Medicare will attract the high cost, high risk, older beneficiaries.

Chairman STARK. That is a win for your team?

Mr. BACHOFER. If that is the case, that of course reduces the premiums in the under-65 market for everyone else. There is also an argument that could be made that Medicare will actually attract the lower—some of the lower risk populations, forcing the higher risk population into the private sector.

Chairman STARK. Wait a minute. We are talking about a uniform benefit plan. We are talking about what is basically an indemnity plan which is basically what Blue Cross is.

Figuring people's general aversion to anything governmental, what is it that troubles you about us?

Mr. BACHOFER. Just a comment on the benefit designs. Many of the private plans, of course, will be, though in the President's proposal, the low-cost sharing options because they will be managed care products. Generally more comprehensive benefits have tended to attract higher risk populations. It is possible, although we do not know what direction that selection will take.

Chairman STARK. Tell me the other problems you have. You guys basically are Medicare in most States. Blue Cross is running it. It will be the same clerks, the same 800 number that gives you fits. Give me examples why you would object to Medicare being offered to people under a hundred, same benefit.

Mr. BACHOFER. Well, the first was simply we are not sure which direction the selection is working.

Chairman STARK. You are not sure which direction Mutual of Omaha is going to go either? You do not object to their competing.

Mr. BACHOFER. Right. We also do not have as the—the same control of the price, for example, that the Medicare program enjoys which gets me to the second problem.

To the extent Medicare relies extensively on price control, the control of unit price as a way of controlling costs of the program, that over a period of time, I think that is going to drive providers increasingly out of participation within the Medicare program.

Chairman STARK. That isn't your worry. You let me worry about that. Blue Cross comes to this social concern late in life. So let's just say we will take care of that. Thank you very much.

Mr. BACHOFER. With those as the two uncertainties, the only questions we have are how viable does the remaining private market remain and over a period of time, will people be increasingly driven into the public sector program.

Chairman STARK. Only if it is better service and lower cost; right?

Mr. BACHOFER. That is——

Chairman STARK. I have no other advantage, do I?

Mr. BACHOFER. Yes——

Chairman STARK. You guys want to compete. It is interesting. I hear this on my panel. I don't know of any of my panel that ever had a job in private industry. They talk about competition like they grew up with it. But when I get you guys who are out there in private industry, this idea of competing kind of pales when the competitor looks tough. I always figured when you compete, you take on all comers; don't you?

Mr. BACHOFER. Yes.

Chairman STARK. Let's go back. Do you have any thoughts, Mr. Bykerk, as we go through this, why you would not want to compete with Medicare?

Mr. BYKERK. One comment with regard to that is that you know the hearing today is to discuss risk adjusters. Presumably in this kind of market where we are guaranteeing issuing, community rating, modified community rating, whatever the rating, however—to whatever extent it is limiting the ability to price for underlying risk, to the extent that that is there, we still need a risk adjuster, even if we are competing with the Blues and with Medicare.

So to——

Chairman STARK. I think you might stipulate both of you that if we did, the risk adjuster would be a whole hell of a lot less necessary. If any of you think we will pick off the well-to-do in this country without substantial supplemental policies, I think we aren't playing chess on the same board.

My guess is that we would arguably take most of the Medicaid, uninsured high-risk population by default because I doubt—I don't mean to single out Mutual of Omaha, but I know of no private insurance companies that are out giving extra bonuses to their salesmen who bring in Medicaid beneficiaries. You guys aren't out hustling the high risk areas. The insurance industry is not. I am not sure they are charged with that.

Mr. BYKERK. If they could pay the premium, we would be more likely to. The problem is they cannot pay the premium.

Chairman STARK. I understand that. My guess is that when I suggest this, Medicare or whatever this governmental entity is, I am assuming Medicaid would be subsumed into one governmental plan, would be the safety net program; and just to tell you where

I am coming from, I am more comfortable with people who want to do that. That is us.

We like running plans for the under-served and the disadvantaged. We have to fund it. Profit-making companies don't. I understand that, too. You do not make a lot of money on poor people.

It is not a good business whether you are a banker, an insurance company, whatever. It is unfortunate. That is the case.

I don't make a moral judgment there. I am saying, hey, what I am trying to offer you guys is the cushy part of the market and we take the market that I think government should be involved in; and that is protecting those people—we are going to subsidize already; right? You cannot tell me that you do not want to compete with Medicare because Medicare is subsidized, because, in effect, we are—the President is planning to provide pretty generous subsidies to big business and small bills on this payroll cap.

So the same government that is going to pick off whatever it gets from the Medicare thing; but I am trying to have you guys find a way out because I do happen to agree with Mr. Gradison that with premium caps, mandatory alliances, no salesmen, you guys are out of business pretty quickly, more those of you who have high costs operations than the Blues; or you first.

So I just trying to find a middle ground here where you can stay in business.

Mr. BYKERK. I might offer one consideration in that approach which is a concern that some people would have that you are building a two-tiered system; you know, a better and a worse system. Theoretically——

Chairman STARK. Mr. Bykerk, I think that that is in the President's plan. The minute you say all the poor people are going to get loaded into the lowest cost plan in town, you have to make a hell of a case to me that that is not the trend we are on anyway.

Mr. BYKERK. I cannot disagree with you.

Chairman STARK. All I am saying is if you take the most fragile population and say they are in some plan, aren't they more apt to get consideration from the government? But they are not players.

Historically, what we have done is the government is there as a safety net. Certainly other industrialized nations do that. That is not to quarrel with the fact insurance companies couldn't do it.

It is what their stockholders put them there to do. In your case, it works well. Some of the Blues are trying to go for a profit. We will try to legislate an end to that as quickly as we can. Not that they are not welcome on your side of the ledger, Mr. Bykerk, but that isn't the way I traditionally think of the Blues.

I am trying to find some ground here. You seem to feel that there isn't really a good, definable, scorable, usable method of risk adjustment at this point; is that fair to say?

Mr. BACHOFER. That is fair to say; yes.

Chairman STARK. You could approach it? I think you would agree with that?

Mr. BYKERK. I agree if you get down to the individual level and the wild fluctuations of given risks of individuals, we think there are some methodologies that could approach that, even now or within the next couple of 3 years if you deal with group size or employer or modified employer choice bases.

We have stayed in New York, we are the only commercial carrier that is continuing to write individual business in the State of New York. We have some concerns there because there is no mandate to buy any of our community rating. We are developing interesting statistics out of that.

Chairman STARK. Could you survive in New York without salesmen?

Mr. BYKERK. Without salesmen?

Chairman STARK. Under the rules they have.

Mr. BYKERK. I don't know.

Chairman STARK. Would be tough, wouldn't it?

Mr. BYKERK. Probably. You know, although we could—come closer to doing it with health insurance than life insurance without salesmen. But the—you know, we are still seeing how their risk adjuster works; and as has been discussed throughout the day, we have some real concerns about whether that will actually work, particularly for the individual marketplace. We are staying to see and trying to make a good faith effort to do that.

Chairman STARK. Let me ask, this wouldn't be as attractive to the Blues, but to the smaller companies—and I don't mean the—Farmers Mutual of Richland Center, Wisconsin, Pacific Mutual, that small, what would the HIAA say if, in fact, we put fee schedules into effect for the private side?

My theory is I don't care if we do not. You take that position at your risk because I figure every one of your major customers will be in here the next year begging us to do it. If we continue to have cost containment on Medicare and Medicaid, shove it on to your bills, it is a matter of time before the private side comes in and says we would like cost containment, too, particularly the smaller companies who do not have a market presence.

The Blues have a market presence. They can negotiate. Some of the smaller companies basically cannot. They play in a few markets, but you come into a market where there are 100 insured, they are paying sticker price. You guys have discounts negotiated.

Assuming the private rates would be closer to private rates, about 130 percent of Medicare, I suspect, is where it would come out, does that harm any of you? Does that help you?

Mr. BYKERK. Are you talking about setting the fees or just making them consistent?

Chairman STARK. No. Setting them. In other words, we have it—there would be a two-track fee system, Medicare, bring Medicaid up to Medicare and pay—it would be—we costed it out. It was approximately 130 percent. Some areas, Manhattan, Los Angeles, actually it is under; but some areas, that is a pretty generous payment. It is pretty generous if you figure everybody gets pay, no uncompensated care, no charity care.

Then your smaller insurance members are in the same 40 percent. They can go into a market and they are bidding in with a cost limit at least; and I just wonder if that offends you? It offends a lot of people on the theory they don't want government price controls.

I am saying the opposite of that if you continue to have it on the public plans and you have no cost controls on the private side, it could in time give the smaller companies some problems. I just

wonder what your objection would be to having it consistent? The President's plan is pretty close to consistency if you do away with premium cap. He has rate-setting for fees. He has a premium cap which is what we do in Medicare.

Mr. BACHOFER. We have a couple of reactions to that. The first is if you look at what the plans are doing, we now have 25 percent of the—our membership is enrolled in some form of government-based product. The payment methods that are increasingly used in those network-based products involve broader risk sharing, even than the sorts of fee schedule.

We have also been much more successful in managing utilization than the Medicare program has been. We feel as a result of that there should be some act to select a provider who may in fact have higher prices, but does a more effective job of managing the efficient delivery of services. We feel an all-payer rate schedule that bound us to it would interfere with our ability to construct that.

Chairman STARK. Is that in Maryland? We have an all-payer system in Maryland. You have a lot of complaints with the guys running the system. Other than that, they haven't been troubled by it in Maryland, have they?

Mr. BACHOFER. You still see the development of managed care programs in those States to put emphasis on management of utilization. I cannot speak to the Maryland situation. I cannot directly say whether they modified or have an alternative arrangement to provide the broader risk sharing.

Chairman STARK. I am saying the hospital paid it. They have an all-payer system. I think everybody is happy with it.

Mr. BACHOFER. Certainly the providers in Maryland seem to be happy with that program.

Chairman STARK. All the way from the little rural hospital to Johns Hopkins. They think they invented it—but they fought it 10 years ago. They did not like it.

Mr. BACHOFER. Just an initial reaction is we feel that as we look at provider contracting, moving in directions other than the Medicare direction. It may complicate our movement in those directions.

Chairman STARK. Let me give you your choice. You are not going to like either one. Take the President's plan with premium caps as is, no salesmen, community rating; or my plan which gives you your choice. Leave it up to the States. Whether you take our cost controls or not. But Medicare is available, is offered for individuals in the markets you are in, and you all continue to do what you are doing.

Mr. BYKERK. Well, I personally—

Not speaking for HIAA, but I think I would choose your option because at least we could stay in there and compete.

Chairman STARK. You would stay in business.

Mr. BYKERK. Our perception at the current time is given the exact way the President's proposal is formatted today, we would not be in business for very long.

Chairman STARK. Mr. Bachofer.

Mr. BACHOFER. Certainly a Hobson's choice.

Chairman STARK. Yes.

Mr. BACHOFER. I think we would have to look at that sort of choice very carefully. We do not feel you need premium caps in

order to get cost containment. If you enact comprehensive market reform, the competition itself will drive costs down fairly aggressively and fairly sharply.

Chairman STARK. So seeing we increase your intermediary business if I pick up any more business, you guys have a win-win situation with my plan, don't you?

Mr. BACHOFER. Well, I am not sure all the plans would see it in quite that way, of course. I think part of the problem we want to look at is what does happen to the viability of the private market under such an arrangement.

Chairman STARK. Do you want to know what I think?

Mr. BACHOFER. I would love to hear that.

Chairman STARK. You would probably end up, except for the very big companies in low cost States where you could beat us, in the inner cities, high cost markets, you would lose money to Medicare because our overhead is less. You,, particularly Mr. Bykerk's companies, would go into the supplemental business, which ain't shabby business, I might add.

If you limit the long-term liability for the big operations like yours where you are in the intermediary business, and seem to like it, you stay in that, and we take the long-term liability off your back as people shift into a basic—being far lower than generosity than what the President is offering, so you do 180 million new customers basically for Medicare. That seems to be the result, I think, over 10 years if you bought into my plan.

Mr. BACHOFER. If I could, I think I would see a somewhat different dynamic operating in the market under those arrangements. The one point you made I think is extremely important. That is what happens to the benefit package offered under the public sector program.

If it is substantially less generous, then it would tend to be attractive to the lower risk population, the younger folks, men under the age of 25 who think they are immortal. You wouldn't potentially have to deal with the adverse selection problem against the private insurers in the market.

Chairman STARK. You would have the same program.

Mr. BACHOFER. If that Blue Cross is uniform, that would be possible to offer it.

The second thing, I think you would see the private sector doing what Medicare has proven unable to do. That is, going in and developing their ability to be integrated health care systems to operate on a per capita basis.

Chairman STARK. That is OK with me.

Mr. BACHOFER. What you see is the population dividing into two groups.

Chairman STARK. I carry it further. I say given another 5 years after that, you would find this movement to group practice, however you want to define it, I think that will happen regardless of whether we have a bill or not. In 10 years you will find that going on.

So South Carolina, which has 3 percent now of people with managed plans, or California, with 70 percent that, is coming in, there is nothing any of us can do to stop that. I see that happening.

In that much time, Mutual of Omaha is going to think of 18 new products to sell to make their stock holders very rich or Florida executives very comfortable.

Mrs. Johnson has a completely different plan to solve the problems. She is going to get you to buy into her plan.

Mrs. JOHNSON. Thank you, Mr. Chairman. I will be brief. Time is late now.

Before I go to my questions, I am really fascinated by your response to the chairman's question about competing with Medicare. He has asked other panels this. Everybody sits there with sort of an anguished look on their face. It strikes me the reason you do not want to compete with Medicare is because they are not playing by the same rules.

They don't have to cover all their administrative costs. They have an administrative subsidy. Second, they cannot go broke. I mean, if they get no customers in their plan, they will still be there. You have to make it.

I think that that is a fundamental, very significant difference. It means you are not competing with Medicare like you are competing with anyone else. But frankly, I think you are stupid not to want to compete with Medicare.

If Medicare is cut the way the President anticipates it is going to be cut, and it has to because that is where the cost savings come from, the only way that Medicare can sustain those cuts is to cut reimbursements to providers. If you are competing out there in the under-65 group with a plan that is going to pay physicians less than the cost of care which is what Medicaid is trying to do now, you are going to go run up against what Medicaid ran up against. That is, doctors will not take in patients.

Why do you worry about competing with a plan that has a fixed fee schedule, that cannot deviate from it, that has more paperwork than any other system and can't get out of it because you have to document 1 of 5 levels of office visits. We are not going to change that, because that is our cost control mechanism. You can change that.

You can eliminate any documentation for what kind of visit it is. I mean why do you hesitate? Men, I say, let me at you. Get in my market with your fixed-prices, your global practice, your premiums that will ratchet down. We will have you—we are coming frontwards and backwards on quality and cost as well; absolutely.

But I cannot understand why we get this sort of flaccid response from the private sector about competing. I understand your anguish. They cannot compete themselves out of business. Be up-front about it. It is not that you are fixing prices. You are going to back your guys even if they go under.

It is like unfair trade. It is the same people who complain about unfair trade subsidies who want to put you in the private sector up against somebody with an unlimited subsidy back there. If you disagree with me, speak up. If you agree, let me hear why. Why would you be afraid to competed with a price fixed system that will reimburse its providers?

Medicare, you have to. They have that captured. Then it costs you. Not in this market.



Mr. BACHOFER. I think the real problem we have is simply the point you just made. That is that they aren't playing by exactly the same rules. Being able to understand the—how the competitive market would be affected by that, would we in fact continue to be able to offer a product or would the private sector in general be driven into a selection spiral where eventually we are completely priced out of the market. It is that uncertainty that I think accounts for some of the anguish.

Mrs. JOHNSON. You have the right to make some of the assumptions you want. You ought to have a far better answer to the chairman on this issue.

Chairman STARK. Will the gentlewoman yield? The interesting thing is—her facts are quite right. If you look at the President's plan, he has the same cost controls that we have in Medicare.

Mrs. JOHNSON. I have been trying to point that out at every hearing we have, Mr. Chairman.

Chairman STARK. But you see what I am offering them, he sets rates for fee-for-service.

Mrs. JOHNSON. Right.

Chairman STARK. And he sets premium. We set premiums in Medicare as well for the risk. We don't have many, but we set them. As you heard earlier, we pay too much.

So both plans have cost control in them and I am letting it out. That is why I think—we agree with each other. It is the President's plan that has cost containment on both sides and they wouldn't be privy to the negotiations; the negotiations as I read it go on between the National Board of the alliance—fee-for-service rates, the State negotiates the fee-for-service rates that you all have to live by in your indemnity plans; and I presume they do in the fee-for-service—the hospital program would be the same. So it is the same.

Mrs. JOHNSON. I think it is very important that the President's fee-for-service plan is modeled on the current Medicare plan where from Washington you set the rates that will be provided to every provider. We have had a terrible problem with that from Washington.

It has encouraged cataract surgery far beyond any rational reason or need for cataract surgery. It has discouraged the use of certain medications that would have been excellent. It has prevented reimbursement for preventive care because the law doesn't cover it.

Don't look to Congress for progressive leadership on health care. We do not do prevention, thank you very much, because we cannot change the law to do that. The system reimburses willy-nilly.

If it delivers to the market, it is 5 years later before we notice it. fee-for-service with the fees set from Washington is our answer, backed by a global budget. That is exactly the model of the President's program. That is exactly why I believe it will not work. If I were you, I would be thrilled to get out there and compete with it. It will be like Medicaid in 5 years and you win.

Anyway, that wasn't my question. I just think that you ought to come back here and grab the bait when the chairman gives it to you, instead of acting so sad and defensive as if somehow you cannot compete with this marvelous thing we created. Come on, get going. Battle.

Mrs. JOHNSON. Now, my question then, you can answer it fairly briefly because the hour is late, but it does seem to me from all the testimony we have received today, and you were here for the last panel.

Unfortunately none of the panelists of that last panel is here, but their answer to me about, getting non-English speaking oncologists, the more I thought about it, the more I realized how terribly absurd that was. The only accountable health plans that are going to be able to operate in this environment and any alliance worth its salt is going to require that accountable health plans have an English speaking institution, at least a few on staff.

So I don't buy that level of risk selection that was proposed in the last panel.

So my question to you is, how much gaming can an account system do in an environment in which there are insurance reforms, all that guaranteed issue, guaranteed renewability, oh, that is, tough limits on preexisting conditions, AHBs have to be certified, have to charge the same amount for a plan so the HPPC is not sold through the HPPC and there are quality assessment reports every year so that if someone is manipulating their plan in a way that means people don't select it, that comes through.

I don't take that because all of their oncologists speak German. Now, that would come through.

So it isn't as if those subtle ways in which the market is going to be gamed wouldn't become public information given those three things, quality assessment reports, insurance reforms, and a standard benefit plan, I include that in insurance reforms, how much gaming can be done and how much risk adjustment problem is there.

Mr. BACHOFER. We would agree with you, Mrs. Johnson that if you have comprehensive reforms, it would include all the items that you identify and perhaps a few beyond that, such as the certification of adequate capacity, not only for routine primary care, but also specialized services within the product, and the availability of information on consumer, subscriber satisfaction.

You can make that information available to the public in a way that limits the ability of the plan to egregiously manipulate through the design of their product which high risks they avoid within that market.

We do think there is one area that we may need to look at carefully, that is the extent to which you allow very small health plans that serve very narrowly drawn geographic areas to emerge. For that reason, we do want the health plans to be large and pretty much be able to serve at least a substantial portion of a given market area.

Mrs. JOHNSON. I think that most bills do require any AHB to be able to serve the whole alliance area or a substantial portion, but since that would be up to States, it is hard to imagine that they would allow that because that would be identified easily as a risk-selecting mechanism.

Mr. BYKERK. In the structure that you just laid out, would you be assuming that risk adjusters would not be necessary? Is that part of what you were saying?

Mrs. JOHNSON. I am just wondering how much selection there would still be given that kind of market and that kind of environment.

Mr. BYKERK. Well, if there wasn't some kind of adjustment mechanism to deal with it, there would, I am certain, be some attempts in subtle ways to——

Mrs. JOHNSON. Let's name them. See, I want to get at this, because I agree, you have to have, in any model, the insurance commissioner watching both risk selection within the groups and between the groups if it is a voluntary HPPC between those in and outside the HPPC, and then he has to be required to address it.

I think New York is doing some creative work and so on and so forth, but it is possible that we are going to find that the more uniformly we structure the market, and the more everybody is just going to participate in the sense of pell-mell on the same standards and they aren't going to end up gaming.

So far there is some reason to believe that might happen, and it looks to me from the outside that given these four things, that most of the risk selection possibilities are taken and so if you think there are things to do, I need to know examples.

Mr. BYKERK. I think one area would be—of limited focused areas, really focusing on advertising on a certain radio station or just having—if agents are involved, I don't know if that is within your bailiwick of what you describe.

Mrs. JOHNSON. In California they are selling most of the plans.

Mr. BYKERK. But if agents are involved, if you have agents just being focused in one area rather than generally available. Now, if you have a managed care approach, and you only are servicing—I mean, if your plans are only in those areas, then there may be some rationale about you don't go over here 30 miles to try and sell somebody a policy if they have to drive 30 miles in order to go under the HMO.

But beyond that, if there were focused areas, advertising——

Mrs. JOHNSON. You are concerned about focused advertising sectors of the market and also agent sell selection.

Mr. Bachofer.

Mr. BACHOFER. I just wanted to come back to one issue. I don't think that the range of options are available. I think that you haven't identified any in your list. I think you had identified all of the principal methods that would be used.

One thing that Dr. Luft remarked though that I think it is worth just considering is that there will always be efforts to identify new such methods, but in effect that is part of the responsibility of the insurance department in certifying health plans is keeping on top of all that.

I would like to make one other point though, and that is that in the long run, I would tend to agree with you that the differences in risk across the products that are offered in a restructured market will tend to be minimal or will tend to reduce.

The problem though is what you do starting off in the first few years of a reformed market where you may begin with differences in risk of 30 or 40 or more percent between carriers, and those are not going to disappear overnight, and so there is a difficult transi-



tion issue that you have to sort of get to that more competitive market.

There is also an issue over the longer term that we are just beginning to understand something about, because we are just beginning to have data on it, and that is that there are going to be differences in the average risks of people who prefer to go into very tightly organized structured staff model type HMOs and those who prefer a more fee-for-service kind of a plan.

And one of the questions that has to be raised is whether that kind of risk difference is something that we really need to worry about, and again empirically we really don't know if that will trigger some sort of selection spiral against the plans that attract the higher risk population, most likely the fee-for-service or open panel will.

Mrs. JOHNSON. Voluntary reorganization of the small group market will allow this movement at a more gradual pace and if there was the specific requirement to monitor that market for risk selection and the requirement could then apply a risk adjuster, if necessary, both in and out of the purchasing cooperative, would that satisfy your concerns?

Mr. BACHOFER. That is substantially correct. That is why we are advocating as we move into reform, that you really don't need to reform the entire market all at once with all elements of reform.

There are some elements we feel that should be applied across all market segments, for example, standard benefits and guarantee issue.

Mrs. JOHNSON. One example why the level of reform the administration is looking at holds some real danger for us is in the advertising area. I mean, never have we said, ever, in any sector, that government would have complete control or a government-established entity would have total control.

I mean, talk about censorship. This is the society born on the idea of free speech, that any ad or any public statement about your product has to go through a government established entity to be certified.

Chairman STARK. FDA.

Mrs. JOHNSON. Yes, and that is a very limited—right, and that is a good analogy but with enormous implications and very complicated chemistry and stuff that only professionals could deal with, but it does worry me to jump immediately into advertising control.

I spent some of my career as a State senator overseeing Connecticut's sunset laws and one of the things we found was how control of advertising controlled entry and ended up creating monopolies in a very narrowly focused and restricted profession.

So thank you very much for your testimony. Thank you, Mr. Chairman for your tolerance of my outbursts about their responses to you.

Chairman STARK. I need all the help I can get. Gentlemen, thank you very much. Your participation has been helpful and we will be talking with you as we go on in this endeavor over the next several months.

Thanks.

Mr. BACHOFER. Thank you, Mr. Chairman.

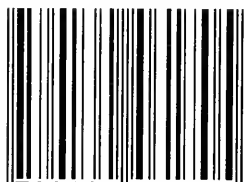
Mr. BYKERK. Thank you.

Chairman STARK. Meeting is adjourned.  
[Whereupon, at 3:25 p.m., the hearing was adjourned.]



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